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IDENTIFIERS	*Indian Health Service (Billings Area); Indian Mental Health Project

ABSTRACT

The fifth volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Billings Area Office. Included in this document are: (1) General Description (geography, demography, and transportation facilities and problems); (2) Social Service Branch Sponsorship Prior to 1969 (development of consultation contracts 1963-68, report prepared for budget hearings December 1968, and outline for Mental Health Career Development Fellowship Hearings December 1968); (3) Continuity: First Chief of Billings' Mental Health Programs (expanding the role learned as a resident, expansion of service unit staffing, serving as an IHS consultant); (4) Discontinuity: Second Chief of Mental Health Programs (two chiefs at once, a new model of service standards, status and power struggles mirrored in the service units, and educational network developed); (5) Efforts to Restore Stability (Associate Arts degree in human services contract, alcoholism program, and decentralized deployment staff); (6) Current Status of Service Unit Programs: 1973 (program descriptions of: Blackfeet, Flathead, Rocky Boy's, Fort Belknap, Fort Peck, Crow, Northern Cheyenne, and Wind River reservations; Intermountain School; and detoxification programs); (7) Summary and Concluding Comments (achievements and problems). (JC)

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BILLINGS AREA

Service Networks
and
Patterns of Utilization

Mental Health Programs I.H.S.

Partial fulfillment of
Contract No. 110-73-342

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

BILLINGS AREA

MENTAL HEALTH PROGRAMS
OF THE
INDIAN HEALTH SERVICE

1963-1973

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Services

Prepared by

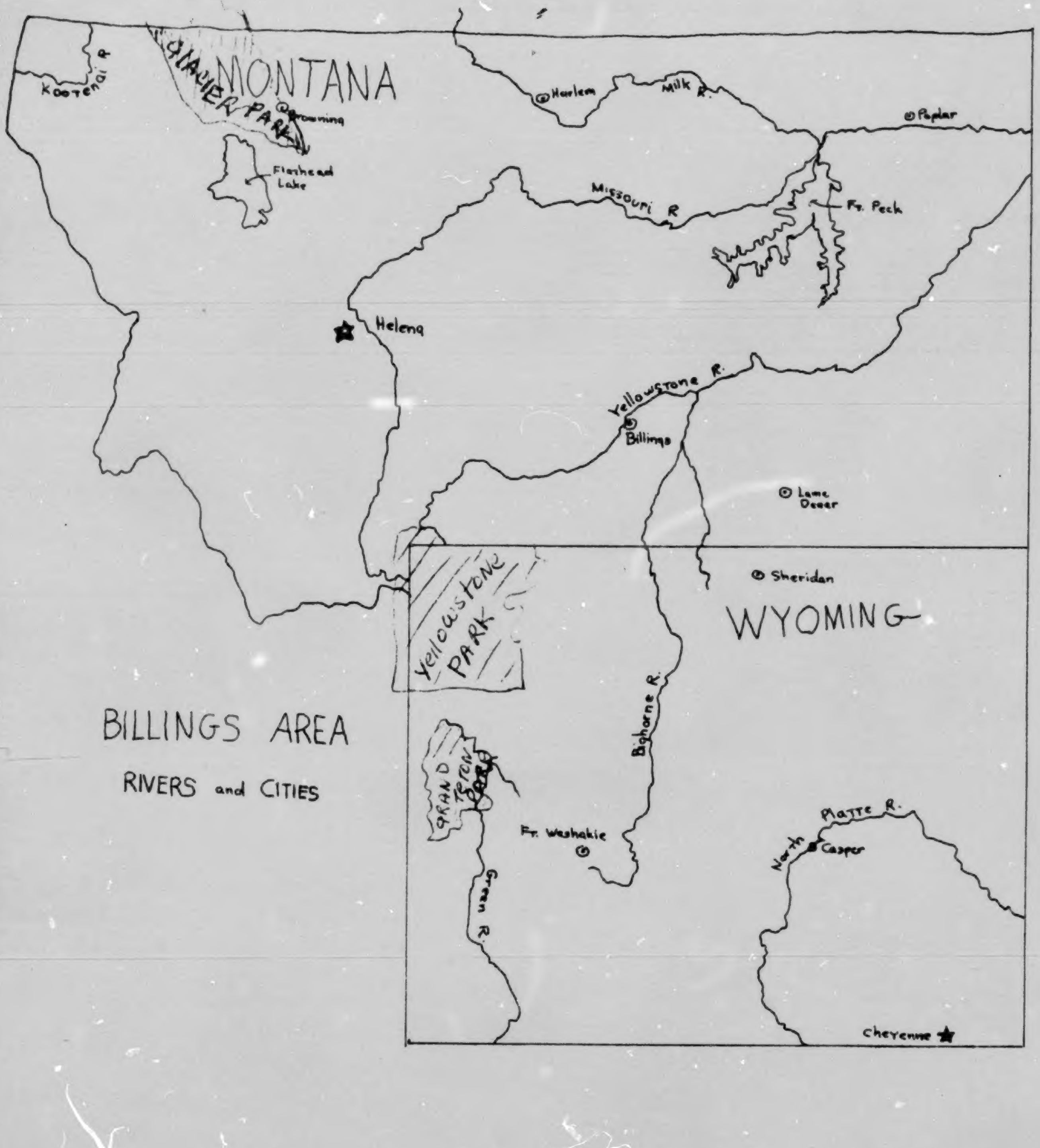
Carolyn L. Attneave, Ph.D. and Morton Beiser, M.D.

Department of Behavioral Sciences, Harvard School of Public Health

This material has been prepared in connection with an initial evaluation contract to appraise IHS Mental Health Programs seven years after their formal introduction into the system in 1966. (IHS Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: One outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1973.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems. and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.


MONTANA
Kootenai R
GLACIER PARK
Browning
Flathead Lake
Harlem
Milk R.
Poplar
Missouri R
Ft. Peck
Helena
Yellowstone R.
Billings
Lame Deer
Sheridan
WYOMING
Yellowstone PARK
Bighorne R.
GRAND TETON PARK
Ft. Washakie
Green R.
North Platte R.
Casper
Cheyenne

BILLINGS AREA

RIVERS and CITIES

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BILLINGS AREA PERSONNEL LIST

Billings Area Office

Frances W. Dixon, ACSW, Area Social Services/Mental Health Officer	July, 1974-present
Margene V. Tower, R.N., M.S., Psychiatric Nurse, Deputy Chief, Area MH Svcs. Br. Chief, Area Mental Health Svcs. Branch Area Alcoholism/Mental Health Consultant	August 8, 1971-April, 1973 May, 1973-June, 1974 July 1974-present
James P. Gustafson, M.D., Psychiatrist, Chief, Area Mental Health Services Branch	July 1, 1971-June 26, 1973
Carl L. Keener, M.D., Psychiatrist, Chief, Area Mental Health Services Branch	June 30, 1969-June 30, 1971
Steven L. Dubovsky, M.D., Psychiatrist Deputy Chief, Area MH Svcs. Branch	July 1, 1973-August 20, 1973
Trudy DuBray, Secretary	February 16, 1970-Dec. 23, 1969
Kaneeta Harris, Secretary Area Social Service/Mental Health	February 2, 1970-to present

Crow Agency, MT - Crow Reservation

Elinor King, R.N., Psychiatric Nurse, Mental Health Consultant (Now Director Mental Health/ Social Services Program)	January 31, 1971-to present
Robert J. St. Marie, M.S., Psychologist Director, Mental Health Program; Mental Health Consultant	July 1, 1969-July 5, 1971
Lamar S. Beatty, MSW (Social Service Branch) Director, Mental Health Program	July, 1971-August 24, 1974
*Gerald Robertson, M.D., Psychiatrist Contract Consultant	No beginning Record-1971
*Jerome A. Chadwick, M.D., Child Psychiatrist; Contract consultant	July 1, 1971-to present
*Barbara Sene, Psychiatric Nurse Contract Consultant	July 1, 1969-June 30, 1972

*Contract Consultants

Crow Agency, MT - Crow Reservation (cont.)

Andrew Russell, Mental Health Worker	December 13, 1970-Jan. 7, 1973
Marshall Left Hand, B.S., Social Work Associate; Mental Health Worker	September 9, 1973-to present
Eilean Big Hair, Secretary	September 4, 1970-June 16, 1971
Mary E. Wallace, Secretary	July 11, 1970-to present

Lame Deer, MT - Northern Cheyenne Reservation

Frances Wilson Higgins, R.N., M.S. Psychiatric Nurse, Director, Mental Health Program; Mental Health Consultant	August 31, 1973-June 30, 1975
Donald R. Wilburn, Social Worker, Director Mental Health Program; Mental Health Consultant	May 31, 1970-August 25, 1972
James Rowland, Social Work Associate, Director, Mental Health Program, Mental Health Consultant	August 1, 1971-1972
(Took Long Term Training 1972-74) Director, Community Health Services	October 1974-to present
*Jerome A. Chadwick, M.D., Child Psychiatrist, Contract Consultant	July 1, 1969-to present
Lazona Bailey, Social Work Associate; Mental Health Worker	October 9, 1973-to present

Brigham City, UT - Intermountain Indian School

T. Brent Price, MSW, Director, Mental Health Program; Mental Health Consultant	March 19, 1972-to present
Dennis O. Wayne, M.D., Psychiatrist, Director, Mental Health Program; Mental Health Consultant	July 1, 1971-June 30, 1973
A. William Haddow, MSW, Director, Mental Health Program; Mental Health Consultant	August 10, 1969-Jan. 9, 1972
*Enoch Dangerfield, M.D., Psychiatrist Contract Consultant	July 1, 1969-June 30, 1973

Brigham City, UT - Intermountain Indian School (cont.)

*Carl L. Keener, M.D., Psychiatrist Contract Consultant	July 1, 1973-to present
*John R. Doige, M.D., Psychiatrist	July 1, 1969-June 30, 1971
*Brian Miracle, Ph.D., Psychologist (Part of Fremont County Counseling Service contract)	July 1, 1971-to present
*Mark W. Rhine, M.D., Psychiatrist	July 1, 1969-June 30, 1970
*Art Merrill, M.D., Psychiatrist	July 1, 1970-June 30, 1971
*Thomas Stapleton, M.D., Psychiatrist	July 1, 1971-June 30, 1972
(All out of University of Colo. Sch. of Med.)	
Robert Holly, Social Work Associate, Mental Health Worker	March 4, 1972-April 20, 1974
Kathy Istee, Social Work Associate, Mental Health Worker	December 11, 1974-to present
Darwin St. Clair, Social Work Associate, Mental Health Worker	March 19, 1972-to present

St. Ignatius, MT - Flathead Reservation

Fred H. Muhs, MSW, Director, Mental Health Program; Mental Health Consultant	December 9, 1973-to present
James Newman, M.D., Psychiatrist, Director, Mental Health Program; Mental Health Consultant	July 1, 1972-June 30, 1974
Joseph Davenport, III, MSW, Director, Mental Health Program, Mental Health Consultant	June 25, 1970-June 15, 1973
Lytle Gillan, Mental Health Worker (Tribe - New Careers)	July 1, 1973-June 30, 1974

Harlem, MT - Fort Belknap Reservation

Robert L. Escarcega, M.S., Guidance Counselor; Director Mental Health Program, Mental Health Consultant	November 11, 1973-to present
Robert L. Morasch, MSW, Mental Health Consultant	January 10, 1971-November 1973
Sybil Colliflower, Mental Health Worker	April 9, 1972-October 14, 1972

Box Elder, MT - Rocky Boy's Reservation

Robert L. Morasch, MSW, Director Mental Health Program; Mental Health Consultant	January 10, 1971-to present
Kathryn Turcotte, Social Work Associate, Mental Health Worker	March 20, 1972-to present

Poplar, MT - Fort Peck Reservation

Charles Trinder, M.S., Guidance Counselor, Director, Mental Health Program; Mental Health Consultant	September 3, 1974-to present
*Charles Trinder, Director, Mental Health Program - Contract consultant	July 1, 1972-September 2, 1974
John Mark Iacovini, M.S., Psychologist, Director, Mental Health Program, Mental Health Consultant	February 21, 1971-Dec. 8, 1973
Lenora Red Elk, Social Work Associate, Mental Health Worker - Alcoholism Consultant	May 27, 1971-to present
Catherine Eder, Social Work Associate, Mental Health Worker	March 5, 1972-to present

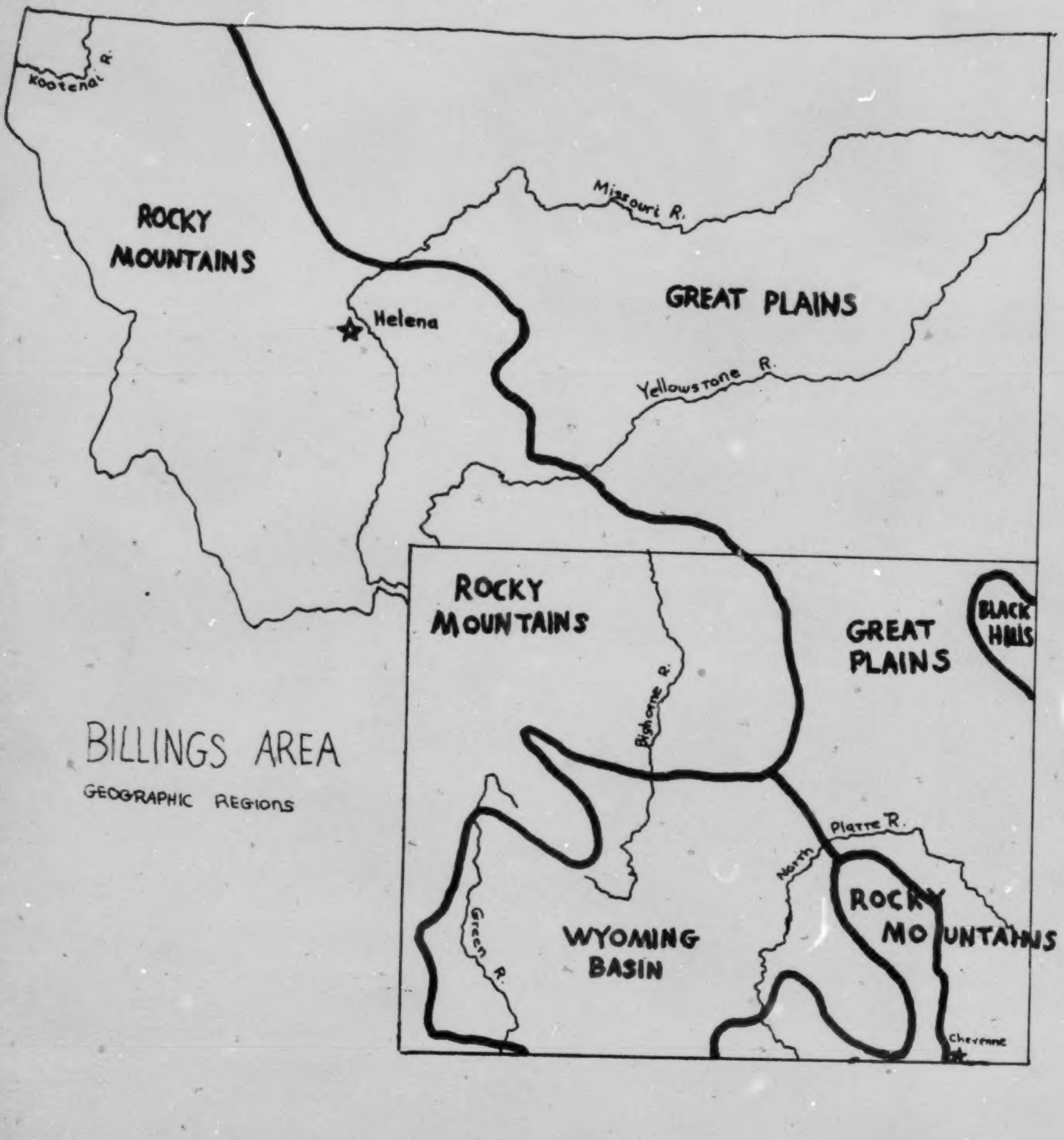
Browning, MT - Blackfeet Reservation

Robert D. Riesenberg, MSW, Director, Mental Health/Social Services Program; Mental Health Consultant	August 16, 1974-to present
Fred Muhs, MSW, Director, Mental Health Program; Mental Health Consultant	December 9, 1973-Aug. 4, 1974
Blaine Wasescha, Ph.D., Psychologist Director, Mental Health Program, Mental Health Consultant	February 16, 1971-August, 1973
Joseph D. Plumage, M.D., Psychologist, Hiline Area Alcoholism Consultant	June 23, 1974-to present
Joanne Nevin, Secretary	May 9, 1973-to present
(Jose Garcia, Social Worker, Social Services)	September, 1969-Nov. 1970

Notes:

There were a few mental health contract consultants before 1969 but records of names, dates and locations are unavailable. Some of the temporary and part-time mental health workers and secretaries are not listed. All of the service unit Mental Health Branches have had, from time to time, temporary aides, i.e., college students doing field experience; tribal programs and contracts, i.e., New Careers, Work Study, NYC, etc. The Social Service personnel were very helpful in participating in mental health activities during the beginning of the Mental Health program, but included in the list are ones that were/are directly involved.

With the Billings Area reorganization, July, 1974, Mental Health Branch and Social Services Branches merged and became Area Social Service/ Mental Health.



BILLINGS AREA
GEOGRAPHIC REGIONS

Kootenai R.
ROCKY MOUNTAINS
Missouri R.
GREAT PLAINS
Helena
Yellowstone R.
ROCKY MOUNTAINS
GREAT PLAINS
BLACK HILLS
Bighorne R.
North Platte R.
ROCKY MOUNTAINS
WYOMING BASIN
Green R.
Cheyenne

I. GENERAL DESCRIPTION

A. Geography and Brief Demography

The Billings Area of IHS serves eight reservations of quite different terrain and tribal constituency scattered over the two states of Montana and Wyoming, as well as the Intermountain Boarding School's high school for Navajo youth maintained by the BIA in Brigham, Utah, near Salt Lake City.

Montana and Wyoming are both crossed by the continental divide, and in their western reaches are composed of the rugged mountain ranges of the Rockies, and their related systems of foothills and rivers. These rugged mountains are apt to rise abruptly, and to have deep river canyons, abrupt waterfalls, completely encircled valleys, and many other dramatic geologic features. The great National Parks of Yellowstone and Grand Teton are found in Wyoming north and west of the Wind River Reservation, while the Glacier National Park in Montana lies between the Flathead and Blackfoot Reservations, extending into an international park at the Canadian border.

The western portion of both states, approximately a third of the total area, is composed of the Rocky Mountains with their various contributory ridges and ranges, and the valleys between them. The eastern two thirds of both states are high plateau country with rolling prairies that are continuous with the Dakotas to the east and southward to Nebraska, Kansas, and Oklahoma. Interestingly enough, this type of country described as "prairie" calls to mind flatness and relatively low elevations, while in the Billings Area the elevations are generally 3,000 feet or more and resemble the steppes of Russian wheat growing sections in the Ukraine.

The name Wyoming, from an Algonquin (Delaware) word meaning "Great Basin" or "Wide Valley," was first applied to the valley of Eastern Pennsylvania. Early settlers, probably from there, transferred the appellation to the great western valleys at the foot of the Rockies. The wide prairies of Wyoming, ringed with mountains, are like an expanded, magnified version of the Pennsylvania countryside, making the metaphor apt. There is no evidence that other Algonquin tribes found in this region used a similar word, but matching the descriptions of early or translated accounts with actual geographic features is almost always difficult because of the many names for the same places applied by the peoples that traversed both states in the course of hunting, trapping and gathering of foods.

Lewis and Clark were the first Americans to explore and map the country, and many features bear names given by them, or given in their honor, including Lewistown, Montana. Before their explorations English language descriptions of the country were sparse and what was known filtered through the French traders, trappers and missionaries. The Catholic church, introduced by the French, is still the largest single denomination in either Montana or Wyoming, and commands the loyalty of the majority of the Indians on any of the reservations.

A good picture of life along the Canadian Montana border as seen through the eyes of a boy growing up there at the turn of the century and learning of its past is given in Wallace Stegner's Wolf Willow. Through narratives like this one realizes that close associations are still latent or active across the Canadian border. It is no surprise that one can be advised to reach the Montana reservations by means of the Canadian Pacific Passenger Service. To reach the reservations from these railroad stations requires driving no less a distance than from airports within the Area, and offers convenient and economical travel options to the east or westbound traveler.

The history of the Canadian border country also offers explanations for the Metis lands which were set aside for French Canadian half-breeds without any promise of federal services from the United States government. These allotments partly honor traditional usage of lands before the border was surveyed, and partly were established as asylum for groups who did not wish to settle in Canada under terms which seemed not to offer full rights of citizenship. These small land grants are still recognized but do not come under service from IHS at the present time.

The following is a brief description of ten IHS commitments in the region,* beginning with four reservations across the northern border of Montana:

1. Blackfeet Reservation

   Blackfeet on the west includes the city of Browning, the "Gateway to Glacier National Park," 1,360 of whose 1,700 people are Indian. The Blackfeet once claimed the Eastern Rockies and their plains from Edmonton, Alberta to the Yellowstone River.

2. Rocky Boy's Reservation

   Almost exactly in the center of Montana's east-west dimension is Rocky Boy's Reservation, named for a Chippewa leader whose name was actually translatable as "Stone Child." This reservation was not created until 1916, to accomodate a group of Chippewa and Cree who had traditionally used the land for at least 100 years even though the basic roots of the tribes were in Canada and Minnesota.

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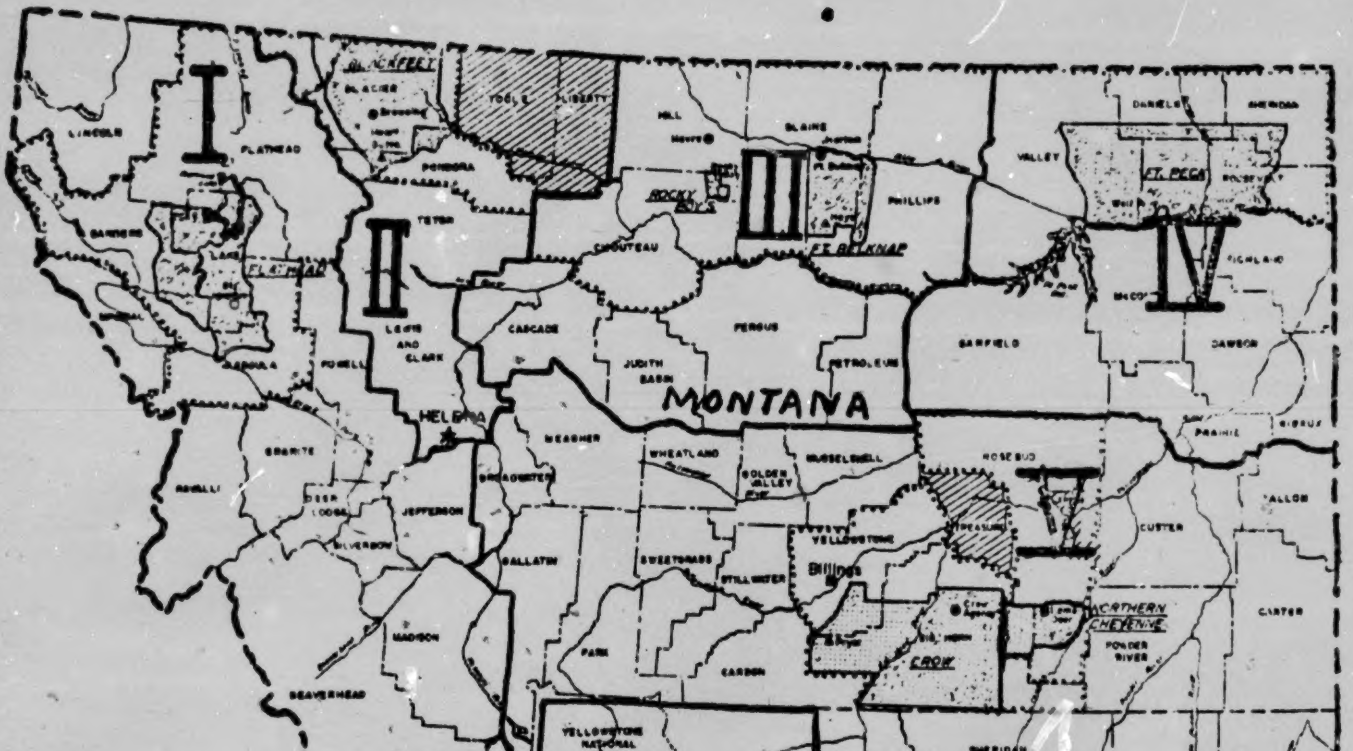
* Mr. Harvey Lich, Office of Program Planning and Evaluation, in recognition of the diversity of geographic and cultural features, under Area Director, Lewis Patrie, M.D., organized and directed the preparation of detailed reports in 1973 of the geographic, sociologic, and cultural features of each of the Service Units, as well as reports on their services for the year. These materials will be quoted extensively in the discussion of the current mental health programs on each of the reservations. For details about population and other characteristics the reader is referred to Section VI where the current (1973) material is included.

BILLINGS AREA

INDIAN HEALTH SERVICE


MONTANA
WYOMING
UTAH
I
II
III
IV
V
VI
VII
BLACKFEET
ROCKY BOYS
FT. BELKNAP
FT. PECK
FLATHEAD
CROW
NORTHERN CHEYENNE
WIND RIVER
HELENA
Billings
CHEYENNE
BRIGHAM CITY
YELLOWSTONE NATIONAL PARK
LINCOLN
FLATHEAD
GLACIER
TOOLE
LIBERTY
HILL
BLAINE
PHILLIPS
VALLEY
DANIELS
SHERIDAN
ROOSEVELT
RICHLAND
DAWSON
McCONE
GARFIELD
PETROLEUM
FERGUS
JUDITH BASIN
CASCADE
CHOUTEAU
TETON
PONDERA
LEWIS AND CLARK
POWELL
MISSOULA
SANDERS
MINERAL
RAVALLI
GRANITE
DEER LODGE
SILVERBOW
JEFFERSON
BROADWATER
MEAGHER
WHEATLAND
GOLDEN VALLEY
MUSSELSHELL
ROSEBUD
TREASURE
YELLOWSTONE
STILLWATER
SWEETGRASS
GALLATIN
PARK
CARBON
BIG HORN
MADISON
BEAVERHEAD
CUSTER
PRAIRIE
WIBAUX
FALLON
CARTER
POWDER RIVER
SHERIDAN
CAMPBELL
CROOK
WESTON
JOHNSON
WASHAKIE
HOT SPRINGS
PARK
BIG HORN
TETON
FREMONT
SUBLETTE
LINCOLN
SWEETWATER
UINTA
NATRONA
CONVERSE
NIOBRARA
PLATTE
GOSHEN
ALBANY
CARBON
LARAMIE
BOXELDER
CACHE
RICH
WEBER
MORGAN
LEGEND
■ AREA OFFICE
▭ INDIAN RESERVATIONS
● PHS INDIAN HOSPITALS
○ PHS INDIAN HEALTH CENTER
▲ PHS INDIAN HEALTH STATION
● PHS INDIAN HEALTH OFFICE
◔ PHS INDIAN SCHOOL HEALTH CENTER
★ STATE CAPITOLS
—— RESERVATION BOUNDARIES
••••• SERVICE UNIT BOUNDARIES
▨ NOT PART OF SERVICE UNIT

——— Intra-Area Reciprocal areas (see Billings Area Office Circular No. 65-13, 1965).

3. Fort Belknap Reservation

About 50 miles east is Fort Belknap where the Gros Ventre (Algonquin) and Assinboine and Yanktonai Sioux tribes, once hereditary enemies, after 180 years of enforced neighborliness have learned to live in peace and to utilize a common language (English). The Milk River flows through this reservation, so called probably because of chalky deposits along its banks near the source, which turn it white in flood times.

4. Fort Peck Reservation

Twice as far east, almost to the North Dakota border is the Fort Peck Reservation which is mainly settled by Assinboine and other Dakota Sioux. On both Fort Peck and Fort Belknap Reservations Cree and Chippewa have settled, but do not share legally in the land and resources except as do non-Indians. They are, however, served by IHS for medical care. A dam has created a large lake flooding parts of the original reservation and much of the land to the southwest between Fort Peck and Fort Belknap.

Since the "Great Northern Railroad" route passes across Montana touching these four reservations, they are often referred to as "along the High Line," an old railroad term. The "Little Rockies" and other ranges separate this string of reservations from the four reservations next described in the southern and western reaches of the state of Montana.

5. Flathead Reservation

A high pass and all of the United States Glacier National Park separate the Blackfeet Reservation from the Flathead Reservation along the eastern Montana border. This reservation occupies a lush valley between two ranges of mountains, the Mission rising to 10,000 feet on the eastern side and the Cabinet and Coeur d'Alene rising 5,000 to 6,000 feet on the west. The two ranges close at both the north and south ends, enclosing the land completely. A large lake at the north, natural hot springs, a swampy wildlife and migratory bird refuge, and a National Bison Range, together with three major rivers and their tributaries, give a comparatively high recreation value to the countryside. The confederated tribes, Kootenai and Salish, who live there are called "Flat Heads" because they did not deform their children's skulls as did tribes to the west. The Flathead tribes have sold much of their fertile land but are now trying to reclaim, buy back and develop resources. In spite of the relative inaccessability of much that they do own, which consists of forested mountains, the Flathead tribes do have control of access to gravel deposits and lake recreation areas. Tensions between Indian and non-Indian residents can become bitter as the Flathead tribe begins asserting its rights and charging for usages which had previously been taken for granted.

One of the oldest and most beautiful of the French Mission churches is still in use at St. Ignatius and plays a central role in tribal life. Other communities such as Ronan, Polson and Dixon are agricultural centers.

From Missoula, 46 miles away where the University of Montana is located, one can fly to Billings, saving a day's driving time, or to the other major cities such as Helena, Great Falls and Havre, Montana, to Spokane, Washington, or to Denver and

Salt Lake City. When weather does not permit flying, one can travel between the Area office and Missoula by Amtrack, but the last leg of the journey is inevitably made by car.

6. Crow Reservation

Southeast of Billings about 30 miles is the Crow Reservation consisting mainly of rolling prairie lying south of the Yellowstone River and bounded across the northeastern corner by the Little Bighorn River and the National Monument commemorating Custer's Last Stand. The Crow Agency, adjacent to the Custer Battlefield, has made an attempt to develop tourist facilities in a motel, the Sun Lodge. In this way they hope to capitalize upon tourist traffic through this area.

The Crow, a Siouxan band, separated themselves from other tribes by their friendliness to the American troops and settlers as early as the 1820's. They were employed as scouts for the army and have some notoriety for having been Custer's scouts. The Crow people, numbering 4,868 at latest count, may appear on the surface to be one of the tribes most assimilated into white culture. However, many of the older ways of thinking and acting still persist.

For instance, although adults utilize English well, children often do not speak anything but Crow when they enter school. The Crow retain not only their language but also the traditional clan relationships which include taboos against direct communication between certain kinship pairs. The visitor may not only see and hear about celebrations such as the Crow Fair, an annual Rodeo and Horse Racing Meet, but also hear of a traditional observance of the Sun Dance. In many more subtle ways the mixture of old and new ways pervades day to day living and can be confusing to visitors and newly arrived residents or IHS staff.

7. Northern Cheyenne Reservation

The eastern border of the Crow Reservation is shared with the hereditary enemies of the Crow, the Northern Cheyenne. This is one of the most isolated, and often considered one of the least assimilated of United States tribes. Their land is characterized by pine forests and rather steep hills, particularly along the western borders, opening to prairie in south and east sections.

The Northern Cheyenne are that portion of Cheyenne who refused to settle in Oklahoma and in 1825 broke away from the larger tribe after its removal to the "Indian Territory." Eluding the U.S. Cavalry until the December snows reduced mobility, they finally accepted the present reservation after a bloody massacre. The two portions of the tribe are in communication with one another, but do not act or see themselves as a group capable of reuniting.

The present Northern Cheyenne tribe number around 2,600 and have retained their language, traditions, religion, and to a great extent have utilized their isolation as a means of preserving their identity as a people. All of this is now threatened by the boom in coal and mineral development.

Until recently, this reservation was served only by one paved road, State Highway 8, which is now being improved from its two lane status in order that it can be designated an interstate road, running east to west. Some of this improvement is needed since the development of oil shale and surface coal just north, as well as on both the Crow and Cheyenne Reservation, has increased truck travel along Highway 8 and State Road 315. These roads run north to Colstrip, which is the site of a large conversion to power plant as well as a primary mining site. The heavy truck travel and the steep grades make maintenance necessary and travel hazardous.

Opening up access to the Cheyenne Reservation is not particularly welcomed by much of the tribe, and there is much ambivalence about how to control it while preserving traditional ways of living. There is considerable underlying depression as it is recognized that the presence of mining and power activities is not preventable even though forces are being marshaled to prevent exploitive development of the reservation itself. Nearby boom towns of 30,000 to 50,000, and the jobs, bars and other associated activities, are real threats to the older Cheyenne life styles.

Some of these deeply bitter feelings are expressed in the ironic joking, typically Indian, that one can hear in the cafes, as well as in the formal Council statements. For example, when a truck speeding through the Lame Deer intersection struck a dog and was overturned, one could hear many remarks that the hound had died defending the reservation, and punning suggestions exchanged that he be honored as a "Dog Soldier." *

Busby is a town on the shared Crow-Northern Cheyenne border, Lame Deer at the intersection of highways 8 and 315 is the major settlement, with the IHS Health Center, BIA Agency, and tribal offices. For a number of years there was no accomodation for strangers,

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* The members of the Dog Soldier Society are highly honored warriors who pledge themselves to never retreat from an enemy and are given the responsibility for defending the women and children in desperate situations.

but a six-bed motel was re-opened in 1973 by non-Indian investors near Lame Deer on Highway 8. Ashland, a major town on the eastern edge of the reservation, is the home of St. Labre Mission, which is known nationally through its fund raising campaigns. From the Lame Deer and Busby settlements on the Northern Cheyenne Reservation secondary roads, mostly graveled, lead south to Sheridan, Wyoming, where there are alcoholism treatment facilities and a Veterans' Administration Hospital.

8. Wind River Reservation

Like the Flathead Reservation, the Wind River Reservation lies in a river valley, long and narrow, and is walled in on three sides by towering peaks. It is approximately rectangular in shape, about seventy miles long east to west and fifty-five miles north to south. The famous parks of Yellowstone, Grand Teton and Jackson Hole are across the mountains to the north and west whose peaks form the continental divide.

The towns of Lander and Riverton, with airports and commercial centers serving the reservation from distances of 30 to 50 miles will be found on most maps. A few maps will show Fort Washakie, the Agency and IHS headquarters, but the rest of the countryside appears unexplored and unpopulated so far as current map makers are concerned. This is a fate often allotted to Indian reservations, and is colluded in by tribes who would rather not be invaded by tourists and explorers.

Two tribes, the Shoshone, who originally roamed this area as part of a much larger territory, and the Arapahoe, whose hunting lands were east and north overlapping the Crow, Cree, Sioux and Cheyenne country, now inhabit the area. In the great effort to settle tribes out of the way of westward migration, the Arapahoe had been removed to Oklahoma and given common land with the Cheyenne. Although the Northern Cheyenne rebelled against this displacement in 1826, it was not until 1878 that the restless and unwilling portions of the Arapahoe were reduced to accepting shelter on the eastern half of the Shoshone Reservation for the winter, and somehow were never again able to leave. In recent years the Shoshone have been paid for their cession of original treaty land to the Arapahoe. The tensions between the two tribes continue to ebb and flow, depending upon current issues. There are two tribal councils, who originally met jointly because the federal government persisted in treating them as a single unit. However, their tribal business is kept as separate as possible. The tribal offices are exact duplicates at each end of the building and the joint council chamber has separate caucus chambers attached.

The Wind River Reservation is in beautiful country, with good climate, and is no further from the Area office in Billings than many parts of Montana. However, it seems different, remote and isolated, and many IHS physicians when talking about their tours there seem to treat it as a Shangri-La. Perhaps this is in part due to the fact that it is the only Service Unit that has to relate to Wyoming's set of state agencies, officials, and local laws. Perhaps it is due to the dependence upon local consultants for professional Mental Health care that a sense of independent existence from Area policies and practices exists. Certainly, with competent staff on the scene, the Area Chiefs have had little reason to divert their attention from the more pressing and sometimes exciting developments in Montana.

9. Intermountain School

Intermountain School in Brigham City, Utah, 65 miles north of Salt Lake City, is a BIA boarding high school where all pupils are Navajo. Indian children from the Billings Area requiring BIA boarding school facilities will most probably be sent to one of the schools in Oklahoma. However, because of certain historical considerations the Billings Area maintains the Health Center at the Brigham City school and has developed some counseling and other Mental Health Services there.

10. Area Office

The Area Office in Billings, while closest to the Crow Reservation, is not located on any of the reservations it serves. Billings, located just below an impressive "Rimrock" and along the Yellowstone River, is the largest city in the southern half of the state. It is the commercial center for both mining interests in the mountains to the west and south, and the agricultural areas to the east and north. A fairly active resort business of the dude ranch variety seems to operate from Billings into the surrounding mountains. In the city itself there are two oil refineries, a sugar refinery processing sugar beets, and a regional electric generating plant.

There are two colleges in Billings, Eastern Montana State College, a four year liberal arts school and part of the Montana State University system, and Rocky Mountain College, a church affiliated college. The Yellowstone County Art Museum, several outstanding private galleries, the Heritage Museum, and a fairly complete medical community all contribute to a tendency to call Billings "The Magic City."

The BIA serves the same two state area with offices in Billings, and a number of other federal and corporate agencies have established offices here.

B. Transportation Facilities and Problems

The availability of transportation may account for selecting Billings as an Area office. There are major airline and bus connections, but Amtrack passe[illegible]r service to Billings is all that remains of the once extensive railroad passenger service.

The Mental Health Programs have not made use of small aircraft, either personally piloted or chartered as much as has been done in a few other Areas. Some Area Office IHS staff have found that small aircraft have usefulness in maintaining contact with reservations in the open prairie country, but Flathead and Blackfoot Reservations have fewer safe flying days than most units in Alaska because of the proximity of towering mountains and the strong winds and air turbulence associated with them. There is some exploration of the potentials of small aircraft or charters when several programs might send personnel in coordinated visits. The easiest reservation for handling small aircraft flight is Crow, about an hour's drive from Billings, but there is some practicality in flying to High Line points. The Mental Health staff has not utilized personal rather than commercial air lines.

Commercial air travel has the same problems that bus or rail service would have if available. The airports and terminals are at considerable distance from the reservations: Great Falls is 120 miles from Browning and the Blackfeet; Williston, North Dakota, is 70 miles from Fort Peck and Havre. Missoula, Riverton and Salt Lake City are "near" in the local vernacular -- around fifty miles from their closest Service Units. This requires that there be a car rental paid on top of the airfare, or that local staff take time to meet planes and drive Area Office consultants to the reservation.

Trains still run across the "Highline" connecting Fort Peck, Fort Belknap, Rocky Boy's and Blackfeet with points in North Dakota or Minnesota on the east, and with Spokane and Seattle on the west, but passenger service is limited to alternate days and is not available to the lower reservations of the Crow, Northern Cheyenne, Flathead, or Wind River. There are not even busses into the Cheyenne Reservation. Both IHS staff and the local Indian populations on all reservations are dependent on cars and trucks, just as earlier settlers with horses and wagons, for day to day practical transportation. They must often take blizzards, heat, and flash floods into account when planning trips.

II. SOCIAL SERVICE BRANCH SPONSORSHIP PRIOR TO 1969

A. Development of Consultation Contracts 1963-68

Prior to 1969 when the first budgeted position for a separate Mental Health program was made available, there had been extensive interest in Mental Health and in its availability to recipients of IHS services. An active program was organized through the persistent efforts of Clayton H. McCracken, M.D., then Chief of Program Services; Frances W. Dixon, M.S.W., A.C.S.W., then social service consultant, and Mr. Thomas J. Keast, M.S.W., Service Unit Social Worker at Crow Hospital. Mrs. Dixon came to the Billings Area (then Sub-Area) by transfer from the Aberdeen Area where she had gained considerable experience and knowledge regarding the Indian people with whom she worked. Interestingly enough, she was the first black person to be assigned to the Billings Area office staff, so she represented bi-cultural experiences that were new for both the Anglo staff and the Indians alike. It is testimony to her persistence and her keen interest in her profession as well as her empathy and insight into the Indian peoples with whom she worked, that one of the broadest bases for Mental Health programs existed here prior to any formal budget being alloted for this purpose.

With the support of the Area Director, the assistance of the Service Unit staffs, and the use of contract funds, she arranged for extensive consultation programs utilizing the Veterans Hospital at Sheridan, Wyoming, to reach the Crow and Northern Cheyenne. Later, psychiatric residents and faculty from the Medical School in Denver served the Flathead, Blackfeet and some of the Highline Service Units in similar ways. Local psychiatrists in Caspar and Cheyenne offered contract services to Wind River until the development of a comprehensive Mental Health Center which has taken over many of these functions.

1. Crow and Northern Cheyenne

a. V.A. Hospital, Sheridan, Wyoming

This early consultation at Crow-Northern Cheyenne Service Unit is recorded in a 1963 letter establishing the contract with the Veterans Administration.

DIVISION OF INDIAN HEALTH
Crow Indian Hospital
Crow Agency, Montana
December 10, 1963 5086/00

Thomas B. Stage, M.D.
Hospital Director
Veterans Administration Hospital
Sheridan, Wyoming

Dear Doctor Stage:

This is in reply to your letter dated December 2, 1963, explaining the requirements for establishing a psychiatric consultation service to this institution. After no small effort, we have finally arrived at a means to a potentially successful arrangement for your services.

First of all I would like to formally request that you provide once weekly psychiatric consultation to the Crow-Northern Cheyenne Service Unit. I will not attempt to specifically designate the site of the consultations as we feel this should be left completely flexible. We will, of course, provide you with advance notification as to the site of your next consultation. However, this can be done at the end of your previous visit or through correspondence between us or between you and Mr. Keast. This has several advantages: (1) It allows us to meet the patient on his own ground, and (2) we can vary the funds from which we meet your fees depending upon current allotment balances. I hope this meets with your satisfaction.

As to billing, all bills should be addressed to Service Unit Director, PHS Indian Hospital, Crow Agency, Montana. However, on your statement it would be helpful if you could show where the service was rendered. That is, you should show on your statement the site where the consultation service was rendered. This will help us in substantiating the withdrawal of funds from various allotments.

The fees (*) which you discussed in your letter of December 2, 1963, are quite satisfactory. Also, billing us for the cost of your vehicle operation is quite reasonable and acceptable.

I trust that we will have a most pleasant and rewarding relationship. I don't believe it is redundant to again mention how welcome your help is.

Sincerely yours,

Malcolm L. Doncaster, M.D.
Service Unit Director"

(* $20.00 per patient visit
reduced to $10.00 by
inter agency agreement

In April of 1964 the contract arrangements became effective, and Dr. Thomas B. Stage, the V.A. Hospital Director, began regular visits. His first services were provided in a medical model as consultations to the physicians at the Crow-Northern Cheyenne Hospital. This shortly expanded to include other hospital staff, and then to include some direct patient care on a limited basis.

In the summer of 1965 Dr. Stage, together with Thomas Keast, M.S.W., who was the IHS Social Service staff member attached to the Crow Agency Hospital, wrote out observations of the first year's experiences in providing mental health care. A mimeographed copy was found in the files, and later search verified the publication of the paper in Hospital and Community Psychiatry, Vol. 17; 1966. The publication carries the usual disclaimer that it is the personal work of the authors and that their opinions should not at that time infer the official support or endorsement of either the Veterans Administration or U.S.P.H.S. Not only because this paper represents one of the earliest published reports of IHS mental health, but also because it contains much that is insightful and that seems to need frequent re-statement, it is included here in full.

Psychiatric Consultation with the Crow and Northern Cheyenne Indians

Many of the Indian tribes of North America have been studied extensively by anthropologists. Seldom have their findings been used in a program of psychiatric evaluation and treatment of Indian patients. Frequently the mentally ill Indian receives no treatment or is treated by someone who only occasionally sees Indian patients. Often he is sent to a distant mental hospital where he is placed in strange surroundings and treated by mental health professionals who know little of his cultural problems. A few psychiatrists and psychologists have made intensive studies of individual Indian patients (1), studies of specific problems of Indian tribes (2-4), or have studied a total tribe (5-8). Studies using intelligence tests and other psychological tests have been done a number of times with Indian children (9-14). Seldom have these studies progressed to treatment programs. The few treatment programs have usually been in conjunction with Indian Boarding schools (15).

Mr. Keast, a Public Health Service clinical social worker, and I have provided a psychiatric consultation and treatment service for the Crow and Northern Cheyenne Indians for the past one and one-half years. The adjacent reservations of these tribes are located in southern Montana and are served by a Public Health Service hospital at Crow Agency. Several full-time and part-time medical out-patient clinics are scattered about the reservations. The hospital and the clinics are staffed by Public Health Service physicians who are serving their two-year military obligation. Therefore there is rapid turnover of medical personnel. Indian patients are referred to us from the hospital and the out-patient clinics or come by self-referral. Due to the location of the hospital on the larger more populous Crow reservation, we have seen more Crows than Northern Cheyennes.

Both tribes are plains Indians and fortunately both tribes have been studied extensively by historians and anthropologists (16-20). The Crow Indians lived in the same general area as their present reservation before the coming of the white man. The Cheyennes were originally woodland Indians from the Minnesota area and were pushed west by the pressure of white settlement. Prior to the coming of white men to the far west the Crow and Cheyenne Indians were frequently at war over control of the hunting grounds in eastern Montana and Wyoming. When the white men came to the area the Crows were relatively friendly and served as scouts for the Army during the Indian wars in the West. On the other hand, the Northern Cheyennes were one of the tribes that held out until the bitter end. In June 1876, more than 250 men of the Seventh Cavalry Regiment under Custer accompanied by Crow scouts were annihilated in the Battle of the Little Big Horn by combined forces of Sioux, Arapaho and Northern Cheyenne. This battle occurred about one and one-half miles south of present Crow Agency. Probably as a result of their earlier acceptance of the whites, the Crows occupy a larger reservation made up of better land than the Cheyenne reservation. The Crows began to accept the white culture earlier and to intermarry with whites and other tribes. The Cheyennes have remained more isolated. poorer, and less educated. A greater percentage of Cheyennes are of full blood. At the present there are about 3,000 Crows and 1,800 Cheyennes living on the reservation.

Prior to establishment of our service, no psychiatric services were available to this Indian population other than for emergencies. In these rare instances patients were usually hospitalized for a few days in the psychiatric unit of a general hospital in the nearest large city prior to being sent to the Montana State Hospital. When we started the consultation service, we decided it would be worthwhile to compare our experience to previous experiences in predominantly white out-patient settings. We began the service with some misgivings since we knew so little of the Indians' culture. We wondered if our efforts might turn out as have so many with these groups, to be only meddling rather than providing a worthwhile service. We were forewarned by persons who had had limited contacts, as well as by some who had many years of contact with Indians, that they would probably not keep appointments, would be uncommunicative and emotionally unresponsive. Certainly if these predictions proved true it would make the operation of a clinic of the usual nature completely unsuccessful. We decided not to set up a rigid structure but to visit the patients in their homes or wherever possible to carry out our purpose. This has seldom been necessary. Although we have seen some patients outside the clinic, we have operated generally as does the usual out-patient clinic. Most patients keep appointments about as well as white patients. This has been surprising as many patients came long distances over very poor roads.

The clinical social worker obtains a social history, school records, and reports of previous contacts with courts, welfare agencies, and medical services, prior to my weekly visits. This practice enables me to make maximum use of my time as psychiatric consultant.

Due to time limitations our service started out to be only consultative, but because of the lack of other treatment resources we have done some short term treatment. We have found many of the patients to be more psychologically minded and insightful than the usual white patient. In general, these patients have been quite emotionally responsive in the psychotherapy situation. This is enlightening as most Indians appear to be quite reserved and taciturn in the usual social situation. In most instances our patients have responded well to the usual expressive interpretive psychotherapy.

The presenting complaints of our patients run the gamut of anxiety, depression, aggression, and bizarre behavior. We have found that a large percentage of the patients, including children, have concomitant psychosomatic symptoms. This may be due to the fact that many of the patients are referred by physicians and have been under treatment for symptomatic relief of the psychosomatic symptoms. When these symptoms no longer control the patient's anxiety, he develops further symptoms such as overt anxiety or depression. It is our impression that the number of patients with psychosomatic symptoms is far higher than that of the usual psychiatric out-patient clinic. Psychosomatic illness is frequently related to the control of aggression. The Indian has little opportunity for healthy expression of aggression in reservation life. This is amplified by the fact that competitiveness with fellow tribal members is not considered a particularly desirable trait by the Indian. These factors may partially explain the high incidence of psychosomatic illness.

Certainly any evaluation of Indian patients must take into account the conflict caused by the impingement of the white culture on the Indian culture, and Indian culture on the white. This conflict is compounded by government policies that at one time restricted the Indian to the reservation, at another time encouraged breaking up the reservation and dispersion of the Indians into the white culture, and then still later encouraged the Indians to remain on the reservation and to develop the resources of the reservation. Indians have rarely been involved in policy making. At various times each of these policies, or a combination of them, have been thought to be the best solution to the Indian problem, but none have been totally successful.

Whatever the official policy of the moment, when the young, intelligent Indian develops a relationship with a white person, the white person frequently consciously or unconsciously encourages the Indian to break with his culture. This apparently has to do with the white person's identification with the Indian, and his conviction that the white way is the best way for himself so it should also be best for the Indian. He does not consider the Indian's attachments and security in his family and his tribe. Despite the monotony and lack of urban advantages of reservation life it offers security to the Indian that he can not find elsewhere.

A number of our patients have left the reservation, usually for a large city, on several different occasions. They have frequently made a successful vocational adjustment, but have been lonely and unhappy and have returned to the reservation. Return to the reservation provides a measure of emotional security, but again raises the specter of lack of opportunity and boredom for the Indian who is technically trained and has skills that he can not put to use on the reservation. This pattern of moving away from and back to the reservation may be repeated several times. The moves may temporarily solve a neurotic or reality problem, but do not provide a long-term solution. After several of these moves, some patients begin to realize the conflict is within themselves, that they are unhappy in either situation, and then they seek psychiatric help.

If a white patient states that he does not speak directly to his mother-in-law, and never stays in a room alone with her, the situation is ripe for psychodynamic speculation. If an Indian behaves in this manner, he may be only following the traditions of his culture, to behave otherwise is to invite conflict. Some of the old customs have been retained by certain families, while others have been given up entirely. Their importance must always be considered in evaluating the individual patient.

The most recurring theme in psychotherapy with the Indian patient is the very close, dependent, and frequently ambivalent tie to the family. The family constellation often includes many relatives such as grandparents, uncles, aunts, adult brothers and sisters, and cousins who are rarely considered family in a white community. The culture exacts many obligations to relatives that the white person does not experience. For example, cousins who are destitute may move in with an Indian who has a job or some other source of income and stay for long periods of time. This is a perfectly acceptable procedure among many Indians, who then feel free to move in with the cousins if their circumstances are reversed at a later date.

Our patients frequently resent these demands made by relatives, but to refuse the relative is to court ostracism. This type of conflict frequently precipitates a move from the reservation. In his anger the Indian is frequently not aware of the security that such a custom gives him. Later, because of his loneliness, the patient returns to the reservation and to his family. This is only one example of a type of conflict that is realistically more difficult to resolve because of the Indian culture.

Since psychiatric referral has not been previously available except for acutely disturbed persons who were referred for hospitalization, it is possible that during the first year and one-half we have seen the more motivated patients on the reservations. In future years the referrals may more closely approximate the usual caseload of an established white out-patient clinic. We may see insightful patients of a lower educational and socioeconomic level. Our observations have been made about tribes whose reservations are less isolated from white communities and whose economic and educational level is better than the average tribe. Further study is necessary to see if our findings are applicable to tribes with different cultures.

It is a widely held belief that the incidence of accidents, alcoholism, suicide and mental retardation is very high among the Indians. Accidents are one of the leading causes of death among the Indians (21). About one-half of all accidental deaths involve motor vehicles. On the Crow and Northern Cheyenne reservations accidents are the second most common cause of death (19.2% of total deaths)(22). During the period of 1959-1963, the rate of automobile deaths on these reservations was twenty-eight times as high as the rate for the State of Montana. The amount of alcoholism on the Crow and Cheyenne reservations does appear to be very high, but it is not well documented. Surprisingly few patients with problems of alcoholism are referred to us, although we frequently find alcoholism present in a patient's family. Our belief is that the Indians visualize alcoholism as more of a social problem than a psychiatric problem, and that it is something to be handled by the police, the courts, and occasionaly by Alcoholics Anonymous rather than by a psychiatric service. The community seems able to tolerate alcoholism and other forms of mental illness to a greater extent than a white community. This has been pointed out as one reason alcoholism is so difficult to treat in the Indian (23); he is not censured by the community as is the white alcoholic. It has also been claimed that the suicide rate is high on Indian reservations. This may be true, but the suicide rate of the states surrounding the Crow and Cheyenne reservations is also very high. The incidence of mental retardation appears to be high, but no accurate statistics are available for these reservations. Peyotism is practiced through the Native American Church, but has not been brought to us as either a social or psychiatric problem. All of these problems are of interest to the psychiatrist and each should be studied in the future. Plans have been made by the Public Health Service to establish a mental health pilot project on the Pine Ridge Reservation in South Dakota to determine the incidence of these conditions and to start programs of prevention and treatment.

SUMMARY

The American Indian has been studied by anthropologists and historians and to a lesser extent by psychiatrists and psychologists. Seldom have these findings been used in developing psychiatric treatment services for the Indians. We have demonstrated that a successful treatment service can be provided by personnel who are not extensively familiar with the Indian culture. The usual techniques of psychiatric social work, individual, and family psychotherapy were used in this treatment. Cultural differences and conflicts and their effects upon mental health and psychiatric treatment have been described. We have commented on the high incidence of psychosomatic illness, alcoholism, and accidental deaths. Future areas for exploration have been suggested.

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Very soon after Dr. Stage became available, the Busby Boarding School made a request for services and the BIA teaching and guidance staffs began receiving regular consultative visits. The expansion of interest and the satisfaction received by both V.A. and IHS from these arrangements led to the addition of a second psychiatric consultant, Dr. Gerald G. Robertson, also from the Sheridan V.A. Hospital staff. The two contract consultants divided their attentions, with one continuing to visit the Crow Reservation regularly and the other developing a separate schedule and program for the Northern Cheyenne. The Northern Cheyenne program was based at Lame Deer and developed consultations with both IHS Clinic staff, but perhaps more importantly, also the Tribal leaders.

b. 1967 - The University of Colorado Medical School Residency Training

During 1967 a good deal of the year was spent in planning a conference in Mental Health Problems and Suicide, which was finally held in November in Lewistown, Montana. The Co-Chairmen of the Planning Committee were Frances Dixon, ACSW IHS Social Services Chief for the Billings Area and Frederick W. Powell, ACSW Area Social Worker for the BIA. Members of the staffs of the IHS and BIA installation at Crow and Northern Cheyenne constituted the planning committee, together with Arlene Waldhaus, a Public Health Nurse from IHS Health Center at Chinle, Arizona. Larry Dizmang, M.D., of the NIMH Center for the Studies of Suicide Prevention acted as consultant to the Planning Committee. Dr. Clayton McCracken, Chief of the Billings Area IHS Office of Program Services and Evaluation also worked diligently and long with the planning group.

The Roster of Program participants and faculty included BIA, IHS and State of Montana personnel, and a Resource Faculty of distinguished specialists of national stature. One of these was James Barter, M.D., Assistant Professor of psychiatry and Chief of Adolescent Inpatient Services, University of Colorado Medical Center, Denver. Dr. Barter developed a keen interest in the mental health programs of the Billings Area, and together with Dr. McCracken developed a plan whereby three third and fourth-year residents could be added to the resources at the Crow-Northern Cheyenne Service Unit. They were joined by Dr. D.J. Dolland of Northampton, Massachusetts, who as Chairman of the Department of Psychology at Smith College, had also developed an interest in Indian Mental Health and arranged to offer services while on leave from his academic post.

This staff, consisting of residents in advanced training, the psychologist and the V.A. Psychiatrist divided their responsibilities so that one Resident and one V.A. Consultant were consistently available to the Crow IHS Hospital, and one V.A. Consultant and Resident were consistently available to the North Cheyenne at Lame Deer, and the third Resident and the Psychologist served the BIA Boarding School at Busby and St. Labre's Indian Mission. Dr. Barter visited often, coordinating IHS needs and the University of Colorado Medical School Residency Training Program in Psychiatry for these field placements. A detailed description of this training program was prepared by Dr. Barter and the three first Residents who participated. This report follows on pages 25-31).

Dr. Barter continued the program until he moved to a new position in California. After his departure it was assumed by other faculty, and the arrangement continued until 1973 when the marked reduction in federal support for psychiatric training forced the University to withdraw.

PSYCHIATRIC RESIDENT CONSULTATION
on an
AMERICAN INDIAN RESERVATION

by

James T. Barter, M.D., Jerome Chadwick, M.D., Carl Keener, M.D.,
and R. James Spensley, M.D.

Introduction

In the past few years increasing attention has come to focus on the deplorable plight of the American Indian. Historical precedents have resulted in a complex bureaucratic structure which has been at best ineffective in solving the social, educational, economic, and personal problems of the American Indian. Most Indian families living on reservations exist at poverty levels, and many of the social and psychological problems are those one sees associated with poverty anywhere. An urban slum or a rural reservation have much in common. The mental health problems of alcoholism, a a rate of suicidal behavior, unstable marital and family relations, and educational failure in the schools can be seen to arise out of the sense of futility and frustration associated with poverty from which there is no meaningful chance of escape. These problems are complicated farther for the Indian by the bureaucratic structure of the Bureau of Indian Affairs, which exercises great control over the Indian's life, and by his particular cultural heritage.

It is obvious that social and mental health problems are central factors in the Indians' current condition. Agencies and individuals who are trying to deal with these problems have not been able to recruit and retain enough mental health professionals to help significantly. This paper describes a pilot program which offers one way of providing mental health consultation to an Indian reservation. This program also offers an excellent opportunity for the psychiatric resident to enrich his training by working in a virtually untapped and unknown area of community psychiatry.

Organizing the Program

This program was conceived at a conference on suicidal behavior in the American Indian during discussions between U.S. Public Health Service personnel and the senior author. The Crow-Northern Cheyenne Indian reservations are located in southeastern Montana, predominantly in Big Horn and Rosebud counties. There is a modern 34-bed hospital staffed by the USPHS at Crow Agency. In addition, there is a USPHS Indian health center located at Lame Deer on the Northern Cheyenne Reservation. It was decided to concentrate on these two reservations, which are adjacent to each other and administratively are one service unit. The consultation program as originally planned would address itself to three major areas:

(1) To provide an in-service mental health training program for the permanent professional staff -- physicians, social workers, public health nurses, community health aides, and other paramedical personnel.

(2) To provide consultation to other community agencies such as Head Start, VISTA, and the boarding schools.

(3) To see and evaluate individual patients, with the consultants making recommendations for treatment and providing crisis therapy on a time-available basis.

It was hoped that out of this program there might develop a greater community awareness of mental health problems and a trained cadre of indigenous mental health workers.

The Department of Psychiatry at the University of Colorado Medical Center saw in this program a valuable learning experience for residents to gain some skill and experience in community mental health efforts. Third-year residents were allowed to arrange elective time to participate in the program.

When the outline of the program was established, the senior author visited the reservations several times over a six-month period to familiarize himself with the local situations, identify problem areas where the residents could profitably consult, and to prepare the community for the advent of this mental health program.

In July of 1968 the program began with three residents. Each resident was given one of three major areas of consultation and responsibility: the USPHS hospital at Crow Agency, the Indian school at Busby, and the St. Labre mission school at Ashland. The residents with the latter two responsibilities also provided on-going consultation at the Lame Deer health center.

The consultants traveled from Denver to the reservations on an average of once or twice per month for two days each time. We have provided approximately eight to 10 man-days per month of psychiatric consultation during the past year. The senior author retained his involvement with the program through on-going visits and continuing supervision of the residents' consultative efforts. Below are brief descriptions of each of the three programs which evolved, with an outline of how a typical two-day consultation was conducted.

USPHS Hospital -- Crow Agency, Montana

The primary area of concentration of consultative effort on the Crow Reservation has been at the USPHS hospital. The consultant conducted in-service programs for professional staff, worked directly with patients, and helped medical officers in the management of their own psychiatric cases. In addition, he went into the community with the public health nurses, and made contact with public school administrators and others — the Neighborhood Youth Corps, VISTA workers, law enforcement representatives, etc. — thus rendering direct services to the community.

Initially at the hospital there was a tendency for the medical officers to attempt to give the consultant sole responsibility for a mental health problem without themselves becoming involved. But as the consultant became more accepted and as their own mental health skills improved, the referring physicians became more appropriately involved in on-going treatment, and a few even became enthusiastic about doing psychotherapy under the consultant's supervision.

The public health nurses provide a number of services in the community. They often see emotional problems long before the problems are seen at the hospital, and frequently they are aware of mentally ill people who may refuse to come to the hospital. Since these professionals already have a good relationship with the patients, it is easy for them to counsel individuals and families effectively. The consultant occasionally accompanied a public health nurse on her visits to homes, both to increase his sensitivity to living conditions and family problems in the area and to increase his awareness of the kinds of problems with which the PHN is confronted daily. Public school personnel used the services of the consultant in varying degrees to help them manage behavioral and learning problems. One of the general medical officers at the hospital had some training and interest in pediatrics, and it was possible to involve him in these consultations occasionally.

The consultant's experience was enriched by a wide variety of informal contacts with a great number of community workers. He would at times be approached by someone who wanted to check out ideas for a community project or perhaps enlist the consultant's support and suggestions for a particular program. These informal contacts were most important in enhancing community awareness of mental health problems and creating an enthusiasm for a mental health program.

The consultant was interested in stimulating the community to initiate its own program in mental health. It is hoped that the Indian leaders in the community will take some initiative in establishing community mental health representatives who can come up with meaningful plans for dealing with the multiple problems of suicide, alcoholism, and marital discord.

Indian Boarding School — Busby, Montana

The second resident has worked primarily with the Bureau of Indian Affairs school at Busby on the Northern Cheyenne Reservation. Busby has a population of about 300; the closest town of significant size is Hardin, 45 miles away, which has a population of about 3,000. There are 300 students at the

Busby school -- 175 in the elementary grades and 125 in high school. About half of the students are Northern Cheyennes, and the other half are from several reservations located mainly in Montana and Wyoming. There are about 80 boarding students, and the rest are day students. Boarders are usually placed in the dorm for social reasons (poor home environments, emotional problems, unsatisfactory adjustments at other schools, chronic truancy, delinquency). As one might expect, the boarders represent a significant proportion of mental health problems at the school. Their difficulties are usually reflected in escapist behavior such as suicide attempts, glue and paint sniffing, drinking, and running away from school. Learning and behavior disorders are also frequently seen in this group.

The consultant, rather than concentrating on direct patient care, from the beginning emphasized working with personnel who have primary contact with students. This work involved increasing the sensitivity of the teachers and other personnel so that they can be more responsive to the needs and problems of the students. An additional goal was to increase the skill and confidence of these personnel in dealing with problems as they arise, rather than putting them off or referring them elsewhere.

Most of the time was spent consulting with teachers on classroom disruptive behavior or learning difficulties. Teacher contact also involved discussion of interstaff problems resulting from the geographical isolation of the school and the frustrations involved in teaching in a BIA school which has nearly overwhelming problems at times. Psychiatric evaluation of individual students was done at the request of the teachers when the need arose.

Regular meetings were held with dormitory personnel, usually centering around behavior problems and the maintenance of discipline and control in the dorms. As with the teachers, exploration of staff frustrations often constituted a major part of the meetings.

A third major area of consultation was in counselling the staff about individual problems of students. Since a student with emotional problems is likely to have trouble in several areas, it is common to discuss a particular student with dorm counselling, teaching, and administrative personnel. It has been typical in the past for a student to be having problems in several areas of living without the adults involved being aware of the broad extent of the problem. Because the consultant was able to bring involved adults together from several different areas to discuss an individual student's problem, some consistent and effective plans of action and treatment were worked out which have resulted in an over-all improvement in the adjustment of some students.

The school administrators, several teachers and counselors, the reservation BIA superintendent, social work staff, and law-and-order personnel also met weekly to discuss general issues such as the school's relationship to the community or how reservation agencies could coordinate efforts in working on a particular problem. This meeting was conducted by an IHS physician stationed on the reservation, thus assuring continuity when the consultant was not present. This is most important, for the consultant has tried to act as a catalyst in bringing people together to learn ways of working out their own problems. It was felt that should the consultation be discontinued or interrupted, a lasting contribution toward alleviating mental health problems would persist; this would not have been the case had the primary emphasis been on direct patient contact.

Although working with problems at the school was the major focus, occassional consultation was conducted with self-referred individuals in the community and in the Head Start program, with patients referred by IHS physicians, with VISTA workers, with Community Action Program workers, and in the local Alcoholics Anonymous program. In addition to this, regular contacts have been maintained with interested, influential individuals in the community. On several occasions school policies were changed as a result of community pressure generated by these individuals. Involvement with the governing tribal council has been minimal, but it is hoped that as the program continues, psychiatric consultation will be utilized in shaping future policy decisions relating to community mental health and other appropriate issues.

St. Labre's School — Ashland, Montana

The third consultant has worked predominantly at St. Labre's School for Indian Children at Ashland. The mission school has approximately 440 students — 350 in grade school and junior high, and 90 students in the 9th through 12th grades. The mission is located in a rather isolated area on the edge of the Northern Cheyenne Reservation, approximately 100 miles from a town of any size. Ashland is a rather small town with a mixed white and Indian population, and it has its own school. There are several bars and one restaurant in town, and the movie theater has movies once or twice a week. The school is staffed predominantly by Catholic nuns and priests, although there are some lay teachers and a lay principal. There is a small corps of dedicated teachers who have been associated with the mission for years, but most of the teachers and dormitory supervisors are relatively new and the yearly changeover is very high. The teachers are exclusively white, but most of the dorm counselors are Indian. Many of the new teachers are young, dedicated idealists who rapidly become disillusioned with their inability to effect rapid changes in the Indian children they teach. The counselors and nurse at the mission initially wished to limit the role of the consultant to seeing individual adolescents with behavior problems. On the first visit, six students were scheduled to see the consultant and on the second visit there were five more, plus two revisits. The counselor and nurse, in discussing the students and their progress with the consultant, were able to appreciate that the consultant's infrequent visits could offer little in the way of treatment for fixed character problems. Gradually as they came to know the consultant and saw that he was not there to judge their efforts, they became more open about staff problems. With the increased trust and backing of key staff, it became possible to initiate regular meetings with them, with the dormitory counselors, with the school nurse, and with the chief counselor. This gave those in most direct contact with the students an avenue for verbalizing their achievements and frustrations to people having some power within the administration. It gave them an outlet for negative feelings which prior to that time had had to develop to high intensity before anyone would notice them. This orientation to noticing only severe crises was both ineffective and often destructive for the administration and staff personnel.

As a result of these meetings, the school administration became more aware of the importance of the Indian dorm counselors as role models. This led to an effort to re-evaluate the dorm counselor positions to make them more attractive to more capable Indians.

Basic to the entire approach at St. Labre's has been the premise that a happy and psychologically comfortable staff will be better equipped to deal with emotional problems of the students. In addition, less frequent staff turnover would provide a more secure living situation, which is particularly important in a boarding school where contact with students is more intense and where unusually severe family conflicts complicate school adjustment. A consultant who can view these problems with some degree of detachment and clarify them in a non-threatening way can be of great value to such a school. The benefits to the consultant are also extensive. To be helpful, he must learn to approach consultation gently and build a strong working relationship with the staff before entering high-conflict areas. The cross-cultural aspects of this work are an additional bonus.

Summary

This paper describes a program in which the USPHS and the University of Colorado Department of Psychiatry arranged for psychiatric residents to carry out a mental health consultation program on two Indian reservations. The individual consultation programs which evolved are outlined briefly, and they indicate the kinds of problems which have been met and dealt with.

The authors feel that this program has several positive features which could be reproduced if this type of program were extended to involve other psychiatric residency programs:

(1) Psychiatric trainees represent a considerable reservoir of mental health personnel and usually arrange elective time for involvement in a program of this kind. Since the inability to recruit and retain mental health professionals to work with Indians is a serious problem, trainees could help to fill this manpower need and aid in the effort to alleviate the Indian's deplorable situation.

(2) Working in the program offers a psychiatric trainee an invaluable opportunity for learning experience and consultation in community mental health in an area with desperate needs which has been largely ignored.

(3) The program also offers university and other training institutions an opportunity to fulfill what many consider to be an urgent obligation to help meet community mental health needs in this country, particularly in rural areas.

c. 1968 - Summary Report to Social Services

In April 1968 Michael Baizerman, an IHS Social Worker with specialized interests in Community Development who had been assigned to the Crow Northern Cheyenne Service Unit since February 1966, wrote a lengthy narrative report describing the programs and accomplishments of the Mental Health efforts of IHS at that time. Although it is quite lengthy, much of the report is worth quoting since it established the various programs and activities in this Service unit up to that time. The first section of his report is devoted to the Neuropsychiatric consultation program that involved the staff of Sheridan V.A. and the Staff and Residents from the University of Colorado Medical School.

> I. Weekly Neuropsychiatric Clinic
>
> The Neuropsychiatric Clinic has continued for 27 months on a regular, one afternoon/week basis. Dr. Robertson, V.A. Hospital, Sheridan, Wyoming, continues to serve as consultant. The role of social worker has changed from collecting social data for the consultant to joint interviewing and to development of resources and referral, treatment, and follow up. More and more, staff physicians, clergy, and school staff, etc., are sending patients to clinic for evaluation and then doing "treatment" themselves. This should be encouraged to continue. Each physician or even the total medical staff might be moved along to where a mental health clinic could be held two to three half days/week. Nursing, social work, Public Health nurse, etc., could all possibly carry cases with consultation from Drs. Robertson and Barter, and with some supervision from neuropsychiatric resident.
>
> The social worker should become less a clinician and more a developer of other staff. He should do consultation more, especially with caretakers, such as schools and police. While there has been a radical positive change in our staff attitudes regarding hospitalizing NP patients, a great need remains for training professional and sub-professional nursing staff in the skills of working with neuropsychiatric patients. Sub-professional nursing staff attitudes regarding neuropsychiatric cases are poor because of anxiety and lack of knowledge. In=service education at the service unit is extremely limited. Resistance to neuropsychiatric education is lessening, but still prevalent.

Ancillary services for a neuropsychiatric clinic might be developed:

Psychological Testing

This service could be used and the Personnel Officer. Billings Area Office, PHS; Chief, Psychology Department, Veterans Administration Hospital, Sheridan, Wyoming; and/or trained psychologist from Billings are potential part-time (one afternoon/month) staff.

Psychiatric Nursing

The resident coordinator, University and Wyoming School of Nursing program at V.A., Sheridan, is a brilliant and competent person (Barbara Stankowitz). She might be approached for students in psychiatric nursing for our clinic, for joint work with Public Health nurses, and as leverage for in-staff development of PHS hospital nursing department.

Social Work

A social work aide position should be considered. This person could under supervision of a trained social worker (ACSW) do some of the tasks necessary for an expanded mental health program as well as some of the routine medical social work tasks required. Agency liaison work might be another responsibility.

Health Education

Health education appears to be physical health education almost exclusively. Appropriate supervision and education might profitably lead to an on-staff resource too often used for blood bank and first aid courses where effective use of time is questionable.

Bureau of Indian Affairs

My working experience with the local staff leaves much to be desired. Efforts might well be directed toward involving these workers more directly in case situations of mutual concern, i.e., placement of children in foster homes, mental services, Crow Club activities. This would, in my opinion, permit more effective use of their professional abilities.

Additional Comment

The Northern Cheyenne have received too little support in the past. Dr. Kurtz's Herculean efforts in neuropsychiatric work should be rewarded in several ways, among them more backup social work time. His monthly reports do him no justice. His group treatment program at Ashland and Busby, his faculty meetings at the Mission School, his high, individual caseload, and his development work with potential resources of referral, treatment, and follow up are an extraordinary beginning to a viable community-based mental health program.

> I have no question about the potential for neuropsychiatric clinics on both reservations. It could be developed to demand one full-time MSW (casework) and one full-time aide on each.

In a later section of his report, Mr. Baizerman makes a frank comment about the difficulties experienced when, as a member of the Social Services branch he is attempting to organize preventive programs within a medical model of the Indian Health Service Hospital. These comments have recurring relevance for many programs even with a special organized Mental Health Program Service which attempts to evolve both preventive and treatment services. They are, therefore, quoted in some detail.

Some Thoughts on Other Programs and on Priorities

> Unfortunately, a dichotomy and not a continuity has develped between the clinic program and the prevention program. In logic and in practic, this is untenable. The history of the community health program shows that emphasis was placed on the organic relationshop between these services. Personality, organization structure, and specific actions have brought us to this point; they must be used again to re-institute the healthy relationship..
>
> The strength of white and Indian off-duty relationships appear to vary directly with whether the participants can resolve role problems. Personaltiy and desire to participate are only elements which feed the role. The structural problems are caused by the "trained incapacity" of professional educated staff to be human and "whole" in a way which transcends the internalized role behavior learned in graduate school for socialization into the status and role of professional also are related.
>
> A major barrier to effective health care is our over-reliance on physician judgment at the local level; and our concomitant failure to develop into the structure the role of hospital administrator. For all our talk, I think that we know very, very little about the normative patterns of Indian life today and that we do very little to learn about these. This is an obvious barrier too. I wonder if part of the problem results from not knowing what it is we want to know, i.e., "What is a norm? A value?, etc.
>
> Further, minimal effort is made to teach staff what to look for and how to find it, to learn from staff while they are on duty and to "de-brief" them

> as they leave. Orientation for new staff about tribal culture is often vacuous.
>
> Within the Service Unit, the structures of decision-making are set up to create a bottleneck: The SUD is required to do more than any one human being can. Structurally, his role is sociologically fascinating but realistically impossible to fulfill as effectively as he would wish: Chief Administrative Officer, Chief Medical Officer and staff physician. In exasperation, I refer the reader to the concepts "role conflict," "role confusion," etc. The system which supports the SUD role as defined dissipates any effort at developing responsive and responsible first line supervision, for it does not support them in problem resolution. The BAO with the problems of distance and discipline -- specific consultation worsens the situation. As noted elsewhere, subprofessional staff receive minimal developmental effort. The results of these things are our reality: strong professional staff kept alive by two year turnover with over dependence on physician time and judgment and with almost no competent supervision to nonprofessional staff. I submit that these are the results of poor structure as much as they reflect idiosyncratic personality....

In spite of these difficulties, Mr. Baizerman describes very active and constructive programs in suicide prevention and alcoholism, in which both he as a Social Worker and the psychiatric consultative staff are involved. The establishment of roots for present day programs is often overlooked, and the references to programs which have been developed often proves instructive in making new plans and assessing any program's current effectiveness. Therefore, these sections of Mr. Baizerman's report are given below as bench marks against which to measure later progress. The omissions are references to individuals and specific dates for meetings or events that have little general relevancy.

II. Suicide Prevention Program

> Currently, our Suicide Prevention Program is an integral part of our Neuropsychiatric clinic with most referrals going to Dr. Kurtz, then to our hospital for evaluation by our staff, the consultant, and often the social worker. It is to our credit that we have not yet "lost a case." Yet, much remains to be done. Here again the burden falls to Lame Deer.

More, much more, community education, especially for caretakers, is needed. Social work and health education might assist here. An adequate record system is being developed, though I'm not sure it should be housed with community health. Adequate follow up for treatment demands both an increase in our staff commitment and the development of caretakers' skills. This must be continuous.

I suggest that suicide prevention research be clinical, epidemiological, and anthropological and that the social worker coordinate this effort, because of the clinical base of program and social work familiarity with social science research. The community health director should be consulted frequently. Effort should be made to encourage Mrs. Weist, resident anthropologist at Northern Cheyenne, to apply for NIMH, CSSP grant, at such time she wishes to pursue her now peripheral findings on self-destructive behavior. The number of attempted suicides is not reflected accurately in social service records because the worker does not see many, many cases; and need not, if the prevention system is working. Some other way to collect and report these data in a uniform way should be worked out.

III. The Alcohol Program

The AA Group - This is one of the fastest moving programs we have now; Dr. Barter's program is the other. We began in August with training sessions at the University of Utah under Fenton Moss, School of Social Work. AA meetings began in September at the U.S. Automatics plant (now Shavex plant) in Crow Agency on Monday evenings. We have met every Monday night since. In January, we moved the meeting place to the PHS hospital because the plant closed. In May, the group will probably move to its new tribal-donated clubhouse, the old courthouse in Crow Agency. From one meeting/week on the Crow Reservation, we have expanded to three on Monday at Crow:1:00 p.m. for men on "swing shift" at the Carpet Company; 7:30 p.m. for men working days, not working, and jail prisoners; and 7:30 p.m. for women. Invitations for meetings in other districts are beginning to come in: St. Xavier and Wyola-Lodge Grass. Dr. Tischler worked the evening group with me, and Dr. Dupont works the women's group.

The AA began as the CROW Club - where CROW equals Crow Rehabilitation of Workers. This was done to avoid the stigma then prevalent against alcholism programs in general and against AA in particular. Historically, AA has had little success on Crow. While AA was functional for months and even years, it never was able to develop roots which could provide enduring sustenance.

This is not necessarily bad. Community organization--group formation--is often most effective when group members who have had a positive group experience break up because they feel the group is no longer viable. The acid test of their experience is the individual's ability and desire to reach out to others or an agency staff person to help him begin another group at another time. In short, the group participant who learns that group action and activity is one means of problem solving is a critically important community resident. Past AAs have left many of these people on the reservation, thus making the current organizing job easier in many ways.

Past AAs did not, I submit, sustain themselves because: (a) of the age of the members (40+); (b) of the lack of formal tribal and other agency support; (c) their inability to build the program organically into the culture of the reservation. They may not have made this a "felt need" program as seen by "the communities"--of the reservation. Problems of timing were present too.

Our current effectiveness flows directly from the "pay-off" of sober, working members and the political support behind us. This support was....a silent and little-known part of the organizing job.

Our CROW Club (AA) membership is self-selective and, thus, the fact that all but one member are between 23-40 years old is significant. Based on our groups' feelings, I urge that older participants be helped to organize their own group. Our group can be developed in several ways because of the age and level of education of the members:

They're between teenagers and older people and could organize "down and above." Organizing "down" has begun in work with Charles Smith, BIA Juvenile Officer, Crow. Members now in AA are articulate in English and are interested in working with youth in recreation -- where there is a crying need -- and in Alcohol education in the schools using the Northern Cheyenne text. Tom Keast's work with teenagers on Flathead could be a model...

Both physicians should be supported in their efforts by building our support into their schedules. Further, I recommend that Dr. DuPont be offered training at the University of Utah Alcohol Clinic before June or at Rutgers University.

Dr. Tischler, by medical staff approval, will have primary responsibility for an "Antabuse" program in the factories if this develops. Such a program would need a

> group (therapy) meeting as part of the service. A social worker, neuropsychiatric resident from University of Colorado, a Veterans Administration consultant from Sheridan, and Dr. Dolland could fit in here. Our AA meetings are "fifth step" sessions (see AA Grapevine, current issue) and have elements of group therapy in their structure and content. I urge that the meetings be kept reality oriented and adjustment oriented, not testimonial oriented. Our effectiveness, as measured by number sober over time, supports this point, I think.
>
> I would suggest that whenever possible, separate meetings for men and women be continued. It is feasible to plan for a meeting in every district at least, on a different day/night of the week.
>
> Further, it is possible that a group can be organized at the three industrial plants: Big Horn Carpet Co., Shavex Corp., and Guild Arts & Crafts.
>
> As I have said before and written elsewhere, the industrialization effort of the Crows will not succeed, I believe, unless active, consistent, and effective supportive help (services and policy changes) are begun. The manpower needs of industry may not be met, and the dysfunctional consequences of industrialization on culture and on social institutions -- family, economy, politics, etc. -- will cause havoc. The United Nations can fully document experiences where the cost of industrialization on culture is almost societal suicide. I urge, therefore, that every effort, be it policy, money or men, be made to PREVENT this death. I question whether the BIA understands what could happen. My own efforts after 1 May will be in this Area, both academically and in social action. This must be priority number one - truly public health prevention.....

2. Other Service Unit Contracts

a. 1965: Intermountain Indian Boarding School

With the success of the consultation at Crow Northern Cheyenne established, a contract for consultative services was arranged about 1965 for the BIA Boarding School at Brigham City, Utah, known as Intermountain Indian School. This school is attended entirely by young people from the Navajo Reservation, but is attached to the Billings Area for administration of its health care facilities. Dr. Enoch G. Dangerfield of Salt Lake City provided the consultation, dividing his time about half for direct services to students and about half for staff consultation. The IHS Clinical Director of the School Health Center had been a physician at the school for a number of years and was therefore quite knowledgeable about the faculty and student body. In acute crises she could call the psychiatric consultant directly, and with his support also developed on-going services for students with emotional problems.

The program is cited in a memo from the Area Office Chief of Social Services of IHS as being noteworthy because it is so well known and accepted by the students and staff of the school. Particularly noteworthy was the involvement of the BIA staff, which made the program through 1968 outstandingly effective. The Consultant Psychiatrist took a very personal interest in the students, and extended himself to make visits when he could to the students' homes and Reservation.

b. 1967: Wind River, Wyoming

In 1967 the IHS arranged a contract for psychiatric consultation with the Residency Training Program at the University of Utah Medical Center, Salt Lake City. The consultant assigned also acted as consultant to the Fremont County Mental Hygiene Clinic at Lander, Wyoming, and provided some liaison with that agency. Direct service was developed as the two physicians and the social worker attached to the service unit received supervision and support in carrying out work with selected cases. Those patients more acutely emotionally disturbed were referred to the psychiatrists in Caspar and Cheyenne, Wyoming.

In addition, consultation sessions with IHS staff, BIA social workers, and Lander Mental Hygiene Clinic staff were held monthly. As an outgrowth of this development of collaborative efforts, Dr. Brian Miracle, Ph.D., the Clinical Psychologist at the Lander Clinic, together with one of its psychiatrists eventually assumed responsibility for a major consulting service to the Wind River Service unit.

c. Flathead Reservation, 1967-68

A somewhat different approach than these was utilized at the St. Ignatius Health Center on the Flathead Reservation. The Regional Psychiatric Consultant located in Missoula visited the clinic monthly and held conferences with both hospital and community physicians. A Psychiatric Social Worker who accompanied him from the Missoula Mental Hygiene Clinic made his services available to lay and professional groups of both the Indian and non-Indian community. Since St. Ignatius had no facility for direct medical care for mentally ill patients and no hospital of its own, the staff there had a keen interest in stimulating community planning. The social worker at that time assigned to the Flathead Reservation was particularly active in planning and coordinating community mental health meetings and worked with the Missoula consultants in an effort to stimulate Indian and non-Indian working relationships. As early as 1968 this Service Unit was requesting the assignment of a psychiatrist if one should become available.

3. 1968 Report from Psychiatrist re: Blackfeet Reservation

Dr. Robert Coe Eddy began as a psychiatric consultant to the Blackfeet Service Unit in 1968. He submitted an extensive description of his work and observations after the first few months, and this description is quoted in full below.

PSYCHIATRIC CONSULTATION FOR THE BLACKFEET INDIAN HOSPITAL

Background Information

The Blackfeet Tribe currently consists of 14,000 individuals, 6,000 of which are residents on the Blackfeet Reservation at Browning, Montana. One half of the population of the Reservation is under twenty years of age. Children are highly valued by the Blackfeet. They have permissive care with little physical abuse and only occasional physical neglect. They receive almost no physical punishment. In situations where abuse may occur, children generally deny neglect and defend their parents. The family structure at this point appears to be essentially matriarchal; the grandmother and mother occupy key positions in the family. Children are shown much love and affection, and discipline is generally through shaming. Approximately 30% of the children are breastfed to two months. Most of the breastfed children are weaned at nine months. At two and a half years of age, most children are still on the bottle and weaning is very gradual. Essentially, they can have the bottle as long as they want it. Toilet training in general is permissively handled. Children do not have many responsibilities and are expected to enjoy childhood because their adult life will be grim enough when they reach it.

The social background of the Reservation will be discussed under the areas of psychiatric concern below. Areas of psychiatric interest were presented by Dr. Eugene Brown, Medical Director. There were:

I Neurosis
II Unwed Mothers
III Suicide Gestures
IV Alcoholism
V Adjustment Reactions of Adolescence

I NEUROSIS

A major problem to the Blackfeet Hospital is the large number of patients, particularly women who attend the clinics with vague psychosomatic complaints, complaints of anxiety or depression, and who generally request medication for their nerves. The Hospital has large expenditures for Valium, Librium and other minor tranquilizers. Often domestic problems were listed as precipitating anxiety. Among precipitating circumstances were concern about husband's drinking, poverty, and concern over the behavior of particularly junior high and high school age children.

Comments:

It would appear that the use of minor tranquilizers represents a temporary escape from anxiety without the resolution of chronic reality problems. This use is apparently socially sanctioned both by the population receiving drugs and by the hospital. The burden of human unhappiness dealt with by the physicians is considerable, and the wish to placate it through the use of tranquilizers is understandable. However, in the long run, it probably leads to drug dependency and to a decrease in ego strength in the patients. As a short term suggestion, I would suggest using small doses of the major tranquilizers, such as Thorazine, Stelazine or Mellaril, which are less liable to produce drug dependency. As a longer term solution, it might be possible to establish a clinic with scheduled appointments utilizing the services of public health nurses, a social worker and perhaps community health aids through which such problems would be channeled.

Ventilation of problems and realistic attempts for their solution might be accomplished with less medical time. I would suggest not labeling this clinic a psychiatric clinic. It would appear to me desirable to increase the tribal responsibility in domestic problems. Perhaps this could be accomplished through a community action program.

II UNWED MOTHERS

A large number of unwed pregnancies occur on the Reservation. They occur primarily in teenagers and young adults. Often several children are born to the same mother. Releasing the child for adoption is the exception rather than the rule and brings social disapproval in the majority of tribal members.

Suggestions:

Sexual education of children is desirable at every opportunity, i.e. in the school, the home, the church and the Hospital. It should include straightforward discussion of contraception and of intercourse. The obligations to the unborn child should also be discussed in terms of normal psychological development depending upon the physical presence of two parents in the home. Some sort of "family life education" would be desirable for young mothers, particularly those attempting to raise children alone or with the help of grandmothers. This will be discussed further at the conclusion of this report. Lastly, young overwhelmed mothers represent a high risk group both for their own functioning in terms of their psychological adjustment, the possibility of utilizing alcohol as an escape, and in terms of their children developing problems because of depression leading to neglect. This group would deserve particularly close follow-up by public health nurses and/or community health aids.

III SUICIDE GESTURES

Frequent suicide gestures occur. Approximately 75% occur in females, usually teenagers and young adults. Two successful suicides occurred in the past year, both in girls who shared the same last name but who were not immediately related. From a retrospective discussion of these cases, it would appear that both girls were probably psychotic and provided only limited opportunity to be rescued from their attempt.

Suggestions:

The suicide problem is undoubtedly a very deep-seated one. It involves low self-esteem and the turning of aggression upon the self. In an attempt to decrease this problem, the areas aimed at would be to increase the self-esteem of the Indian teenagers and affording appropriate realistic opportunities for aggression.

IV ALCOHOLISM

Alcoholism is a major if not the major problem of the Blackfeet Reservation. It involves both men and women and contributes as a principal cause of the neglect of children. From a brief stroll down the streets of Browning, it is apparent that the enforcement of laws concerning public intoxication is minimal. As legal jurisdiction both in terms of police arrest and the administration of justice rests with the Tribe, the solution to this problem rests squarely in their hands. Mr. Kennerley and Mr. Dusty Bull presented a proposed program for the treatment of alcoholism. This involved a rehabilitation program and the use of antabuse.

Suggestions:

I would suspect that if little is done about alcoholism, the expectations of improvement for individuals are minimal. Ideally, I believe alcoholism would be handled best by relatively long sentences for chronic alcoholics to a rehabilitation unit. This would permit the restoration of adequate physical health and the training of individuals so involved in some form of employment. After a few weeks, the majority of individuals should be capable of some productive work. During this period, antabuse treatment could be instituted for those individuals who are motivated to abstain from alcohol. It should also be eventually considered that those individuals who have no families would tend to gravitate back to the bars unless some other social alternative is available. Something like a club-house or recreation center for single men might therefore be a useful part of the alcohol rehabilitation program. The activity of Alcoholics Anonymous is certainly to be strongly encouraged.

V ADJUSTMENT REACTION OF ADOLESCENCE

Adolescent behavior is alleged to consist of a good deal of impulsive and binge drinking and considerable sexual promiscuity. Because of these problems, many parents are anxious and concerned about their children, and others wish them to leave the Reservation environment during this period of their lives.

Suggestions:

It is obvious that a good deal of useful energy is dissipated by the youth of the Reservation into essentially non-productive or self-destructive activities. This is not a problem of the Reservation alone but of American teenagers in general. The opportunities for doing useful tasks that are meaningful to, and highly valued by society, are minimal. Teenagers therefore waste their time, their energy and their identity. Teenagers will become more involved in various sorts of useful efforts if these represent their own ideas, if they involve status in the community and if they are approved by their peers. Under those conditions, the amount of effort teenagers can devote to a project is quite amazing. In short, the answer to this problem is to find something else for the teenagers to do. There will always be a certain proportion of teenagers who will be involved in this sort of behavior because of their own individual psychopathology. However, the larger proportion are probably involved in social delinquency because it is considered "the thing to do."

IDENTITY:

An overall consideration of these problems leads me to believe that a central issue is that of identity. Identity might be considered as the inner core of personality concerned with questions such as role, self-esteem, conviction, strength of personality and choice of sexual role. The development of identity occurs in probably three phases. In early infancy, certain problems of basic trust and of self worth are established in the mother-child relationship. The establishment of a sense of worth in infancy is one affected by later developments in early childhood. During a period from 4 - 7 years of age, children learn a great deal about their role in life as a man or a woman, i.e. they learn to copy their parents' behavior. The absence of fathers from the home during this period may critically affect the development of both boys and girls. During adolescence, the child tries out various ways to see what identity he will choose for himself during life. These roles are tried out in general with his peer group. They frequently involve rebellion from parental standards and emancipation from dependency upon the parents.

It would appear that all three of these stages are impaired for some Blackfeet children. First, the excessive drinking amidst some mothers leads to neglect of children, therefore to a lack of basic trust and feeling of worth in their personality. Secondly, the frequent absence of fathers from home limits the opportunity for boys to identify with their fathers and gain a strong opinion of themselves as men. Also, the lack of good work opportunities for men may produce a feeling of discouragement in the children in that they do not see a future for themselves in which they can successfully compete. Poverty and the lack of success in parents may result in their turning some of their anger against their children because of the disillusionment with the lack of opportunity. Lastly, in adolescence, the restricted number of successful possibilities for roles limits the adolescent's view of himself as being able to compete successfully in society. All of these problems contribute to a lack of confidence in sexual role and perhaps therefore to promiscuity and to a lack of self-esteem, which both produces and is reinforced by delinquent activities.

This is a complex, long-term problem. The majority of the solutions should come from the Tribe. To improve Indian identity, this must be an Indian program. The areas I would see where something could be done, would be in infancy, the establishment of family life programs and cooperative preschools. The Head Start program provides a nucleus and a basis for this, and if it is successful, it should stimulate mothers to wish to include younger children. This program will be particularly valuable to the unwed mothers who need both relief from the responsibilities of childrearing and other examples of childrearing to copy. The importance of identification in nursery school children should be recognized. Fathers should be involved in these programs as well.

In the primary period in school, children should be presented with both real and imaginary examples of Indians functioning in successful roles, for example the fire fighters, and in stories, fantasy or discussion of these matters.

In the teenage period, beginning particularly in Junior High School, whenever possible, teenagers should be involved in student government, hospital volunteer programs, committees on any subject they can be led to be concerned with, such as alcoholism, or delinquency, or perhaps the museums of the Plains Indians, churchgroups etc. Opportunities for teenagers to behave in a heroic or courageous way, other than by getting themselves intoxicated, need to be considered; for example, rodeos, hunting trips, camping trips. In summary, I would again emphasize that dealing with Indian identity must be essentially an Indian problem. Perhaps approached through the community action program. The provision of programs that are passively utilized by the children without active effort on their part will probably not be of any particular use. The most desirable arrangement would be one in which they demanded and designed their own programs.

B. Report prepared for Budget Hearings December 1968

In December of 1968 The National Headquarters IHS directed a number of questions about Mental Health activities carried on in the Billings Area in preparation for Budget Hearings to be held in the spring of 1969. Mrs. Dixon provided the answers, and the report summarizes the Area-wide developments prior to the 1968 creation of the separate staff for Mental Health Programs.

1. Specific Details Concerning the Type of Care Given, Clinics Held, Patients Seen.

Patients requiring psychiatric care, depending on the monthly, psychiatric consultation. The type of care is dependent upon the existing need at the time care is provided. This might include actual medication, psychotherapy -- individual and/or groups of individuals; counseling by the physician and social worker forms a part of this service.

Acutely ill patients, more often than not, are referred and transported to the State Mental Health Hospital. However, this procedure is rarely used for the school age child. Facilities and those services required for proper treatment of the school age child or children are nonexistent. At most, he can be admitted to the receiving section, observed and evaluated..

2. What Consultant Services Under GMC Are Available to Each Service Unit?

Blackfeet PHS Indian Hospital

Direct psychiatric consultation was begun at this Service Unit in November, 1968. Dr. Eddy has compiled a report, a copy of which is attached. You will note that the psychiatrist has covered several emotionally laden illnesses and suggestions as [illegible] how these might best be approached. You will note that in [illegible]h problem area discussed, Dr. Eddy refers to the responsibil[illegible]y as he sees it of the tribe on attempts to resolve the problems.

As a result of Dr. Eddy's methods in acquainting himself with existing emotional ills of the various age groups, he will not only provide consultation to Indian Health Service staff. but will serve as consultant to the tribe in assisting them to become more understanding of the implications and complications of the emotionally ill. It is conceivable that as this program develops the staff at the Blackfeet Boarding Home (for students attending public school) will be assisted through consultation and possibly minimal direct services. Dr. Eddy plans visits to the Service Unit once every two months.

Crow-Northern Cheyenne

This Service Unit has utilized consultative assistance from Drs. Stage and Robertson, V.A. Hospital, Sheridan, Wyoming, since January, 1964. Weekly consultation to the staff together with direct services to selected cases, either inpatients, or outpatients are provided. At intervals or at least once monthly he meets with key boarding school staff at the Busby Indian School for consultative purposes.

Dr. Robertson together with three psychiatric physicians from the University of Colorado Medical Center, Denver, are providing rather comprehensive mental health services to the two reservations. This particular arrangement permits greater coverage and more concentrated efforts with staffs -- medical, school, and community sources.

Present assignments of the three psychiatrists from Denver Medical Center are such that rather complete coverage exists. One psychiatrist stationed at Lame Deer Health Center covers the outpatient clinic needs by referral, and (also serves) St. Labre Mission School; one provides coverage to the Busby Indian Boarding School and the third, stationed at Crow, provides coverage to Crow area and surrounding communities, i.e., Pryor, Lodge Grass, etc. This type of arrangement supplemented by the continued consultation from the V.A. psychiatrist provides excellent and more expansive opportunities for consultation with staff and community. Each psychiatrist visits once monthly at different intervals.

Fort Peck, Fort Belknap and Rocky Boy's have access only to services either from the Mental Hygiene Clinics located in Billings and Great Falls, Montana, or from private psychiatrists also located in the foregoing Montana cities (under CMC). These resources are at great distances from each Service Unit. The physicians at each of these Service Units are able to provide only minimal psychiatric care either by permitting the patients to ventilate and/or provide medication as indicated.

Flathead Service Unit

This Service Unit is directing its efforts toward the Community Mental Health approach -- that is, the several counties involved prefer to have consultation provided to their professional and nonprofessional helping groups. Presently, psychiatric consultation is available to St. Ignatius and Polson, Montana, communities once monthly. The psychiatric social worker from the Missoula Mental Hygiene Clinic also provides consultation to St. Ignatius Roman communities once a month for three hours. Meetings are held with combined staffs of hospitals, IHS staff, the clergy, police, BIA, Law and Order, etc.

All children on this reservation, Indian and non-Indian, attend public schools. Since the Missoula Mental Hygiene Clinic and private psychiatrists are within a reasonable distance (50 miles) to the reservation, mental health services from these sources are provided to children under contract medical care.

Wind River Service Unit

There is no boarding school on this reservation. For several years the Service Unit has utilized the outpatient psychiatric clinic, Fremont County Mental Health Center in Lander, Wyoming, which is located fifteen miles from Fort Washakie. In addition, the Service Unit staff and the Fremont County Mental Health staff promoted and initiated joint monthly meetings held at the Service Unit. The meetings serve as a consultation media, not onlv for these two agencies but BIA welfare branch staff. In September, 1967, an additional program was initiated. The emphasis was and continues to be that of providing more direct services through counseling of individuals and groups. These counseling activities are carried out by the physicians, and the social worker (when the latter's services are again available). Psychiatric consultation to the staff is available on a monthly basis by a visiting psychiatrist. Along with specific case discussions, the staff receives advice and direction in the various areas of mental health. care of the acutely ill patients presents difficulties by reason of jurisdictional problems, particularly if commitment seems warranted and distances to the nearest psychiatrist for treatment.

3. Specific Information Regarding Findings and Services Provided to Boarding Schools

Technically speaking, we have only two (2) Indian Boarding Schools in this Area: Busby Indian Boarding and Day School and Intermountain Indian Boarding School. In the Blackfeet Service Unit Area, we have an Indian boarding facility but all students residing in the home are bused to Browning Public Schools. There are two Catholic mission schools, boarding schools: St. Labre located in Ashland, Montana, and St. Xavier, located on the Crow Reservation. Children in each of these institutions have access to and do receive mental health services available on their respective reservations.

School Location and Populations

	Indian	Non-Indian	*
Blackfeet Boarding Home Browning, Montana	150	0	1/
Busby Indian School Busby, Montana	316	8	2/
Intermountain Boarding School Brigham City, Utah	2,104	0	3/
St. Labre' Mission School Ashland, Montana	383	28	4/
St. Xavier Mission School St. Xavier, Montana	114	0	5/

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* 2/ Includes Head Start and 1st through 12th grade.
1/ Thirteen of these are first graders.
3/ All Navajos, 12 years or older.
4/ First through 12th grades (includes 20 Head Start).
5/ Kindergarten through 8th grade.

Intermountain Indian School Health Center

The mental health program at Intermountain Boarding School was initiated in September, 1968, and continues to function smoothly. Here the psychiatric consultant from Salt Lake City gives us 24 hours of service per month. While the Service Unit Clinical Director has scheduled time for her and his psychiatric services, there is flexibility in scheduling activities.

An approximation in division of time and services are as follows:

a. Evaluation and treatment of students - 8 hours per month
b. In-service training with guidance and/or academic staff - 4 hours per month
c. Consultation for social work student trainees - 2 hours per month

At the discretion of the Clinical Director, the Consultant is available for emergency consultation in cases of acute psychiatric occurrences. During interim periods, the Clinical Director provides psychiatric coverage for the Service Unit within limits of capabilities and under the supervision of the psychiatric consultant.

The interest and concern of the Consultant is such that when a student's emotional illness necessitates hospitalization, a minimum of difficulty is involved in admission to the security ward or the state hospital pending disposition. He, being knowledgeable about these students, provides treatment and/or therapies indicated.

4. Specific Data on Scope of Mental Health Program

We have not gathered any statistical data. We propose to do so at the completion of this second full year of service.

C. Outline for MHCD Fellowship Hearings - December, 1968

As a result of a positive reaction during the Budget hearings for which the preceding report was prepared, a budget for a separate Mental Health Program was established for the Billings Area. As a first step, an outline of duties and opportunities for a Mental Health Career Development Fellow was prepared. The program description describes the expectancies and capacities of the Billings Area, and the working philosophy which had become characteristic of the Area staff through the development of the consultant program. This documents the broad base for all subsequent development of Mental Health Programs as an equal and separate "Branch" of Area Services.

PROGRAM DESCRIPTION
MENTAL HEALTH CAREER DEVELOPMENT OFFICER TRAINEESHIP IN THE INDIAN HEALTH SERVICE

1. Organizationally, this traineeship is located in the Offices of the Indian Health Area Director, Health Services and Mental Health Administration, Indian Health Service, Billings Area Office, Billings, Montana.

2. Objectives

The primary objective is to integrate a mental health program in which mental health concepts are to be incorporated in the daily operation of a total comprehensive community health program for the Indian people in the Billings Area. Prominent among those problems which affect the emotional stability of the Indian population are his geographic and cultural isolation, socio-economic adversities resulting from unemployment, limited income and adverse physical environments. These factors precipitate a diversity of social and emotional conflicts among the Indian people. The resulting factors are increased high rates of suicide particularly in the adolescent and early adult age population; high rates of accidents and death due to accidents, excessive use of alcohol, family disorganization and disintegration, child neglect, and a high rate of school dropouts.

In an attempt to ameliorate these manifestations of maladjustment, the Indian Health Service is combating these situations through planned comprehensive community mental health services integrated into the total Indian Health operation. Recognizing the fact that mental illness contributes in a large measure toward accentuating other medical conditions, Indian Health Service is placing major emphasis upon providing care for mental health ills and reducing contributing factors.

3. Duties

   a. To develop and implement an education program directed toward enhancing the abilities and skills of Indian Health Service medical and paramedical personnel in the common aspects of community mental health.

   b. To initiate community education programs for tribal health committee members, agency SIA social workers, county welfare workers, Law and Order, ministers and other helping persons who in course of their daily work have opportunities to improve the mental health of the community.

   c. To provide consultation to interdisciplinary teams in the Billings Area.

   d. Will assist local health and health related personnel, e.g., physicians, Indian Health nurses, community health representatives, social workers, teachers and Head Start staff, etc., in the development of their skills, techniques and abilities to work with parents and to counsel them in mental health concepts related to child care and rearing.

e. Provide consultation to people in the community who are already handling mental health problems as part of their ongoing activities, i.e., community helpers, OEO groups working with alcoholic groups, etc.

f. To provide direct services -- diagnostic, counseling and treatment on a selective basis.

Trainee will be assigned to the Billings Area Office under the general direction of the Chief, Area Office of Program Services. He will assist in determining program direction -- mental health and mental health related. He will serve as consultant to the staff of each of the service units in the Billings Area. Considerable freedom of choice in determining activities will be permissable.

Travel within a three state area, Montana, Wyoming, and Utah, will be necessary. Travel is available via Government automobile or commercial airlines.

4. Clinical Experience

Even though the concept of the DIH mental health program emphasizes consultation and support by the psychiatrist to other professional and nonprofessional people, direct patient care will be an essential responsibility of the trainee.

Within the Billings Area there are three Indian Health Service hospitals, four health centers and one health location -- thus the availability of an excellent opportunity for a variety of direct clinical care experiences.

5. Example of Program Activity

a. Development and implementation of in-service mental health programs for medical and paramedical staff on crisis intervention, treatment and control of alcoholism, suicide prevention and adolescent psychiatry.

b. To establish a community-oriented mental health program and to assist in the application of positive mental health concepts in community-wide activities.

c. Provision of evaluative, diagnostic and treatment services to patients suffering from acute emotional disturbances.

d. Provision of psychiatric counselling to parents, responsible relatives or guardians, and seriously disturbed children.

e. Provision of psychiatric counselling to boarding school staff, and to seriously disturbed children in boarding school.

6. Supervision

The trainee will be under the direct technical guidance of the Chief, Area Office of Program Services and under the Indian Health Area Director. In the absence of a director of an organized mental health program, the trainee will conceivably be responsible in assisting with the development of a mental health team and serve as consultant to it. Psychiatric consultation and direction will be given periodically by the consultant from the University of Colorado Medical Center. Weekly consultation will be available from the BAO visiting psychiatric consultant to Crow-Northern Cheyenne Service Unit, who is Chief of Staff, V.A. Psychiatric Hospital, Sheridan, Wyoming.

7. Time Distribution

Approximately sixty percent of the trainee's time will be spent in conducting consultation to IHS staff, school staffs and direct services when as indicated; twenty percent will be spent in supervised consultation as required and twenty percent will be spent in conferences, assistance in developing workshops, seminars, reviewing data pertinent to his field and participation in other programs of interest.

8. Present Staffing

The mental health program in the Billings Area is in the early stages of development and as such affords an excellent opportunity for career development. There are no full-time mental health staff within the Billings Area. However, psychiatric consultation is currently available to three service units and is being sought for the other four as soon as this can be developed. There is variation in professional makeup of service units. Two have psychiatrically oriented staff. Three have clinical social workers who have had psychiatric experience.

9. Facilities and Communities

Although the psychiatric trainee would be based in the Billings Area Office, he will travel to each service unit to provide consultation and services as indicated. There are seven service units within the Billings Area, five of which are in Montana, one in Wyoming and one in Utah. The total Indian population in the Billings Area is 24,500. Billings itself has a population of 79,016. The trainee can receive the required supervision from three possible sources: locally from a psychiatrist in private practice; from the University of Colorado Medical Center, and the University's Consultant to the Billings Area (Crow-Northern Cheyenne Service Unit).

10. Other Opportunities

He will have opportunity to participate in IHS workshops on mental health; sharing his experience with other mental health workers in the Billings Area and throughout the Indian Health Service.

In addition, he will have the opportunity to attend meetings, conferences, and training sessions outside the Indian Health Service.

III. CONTINUITY: CARL KEENER, M.D., FIRST CHIEF OF M.H. PROGRAMS, BILLINGS

A. Expanding the Role Learned as a Resident

Upon completion of his Residency training, Carl Keener, M.D., was awarded this MHCD Fellowship. The program described in the MHCD proposal just quoted incorporated the basic orientation of both Dr. Clayton McCracken, Billings Area Chief of Community Health Services, and Dr. James Barter who supervised the psychiatry residents placed in the Area by the University of Colorado Medical Center. Carl Keener was one of the residents doing field work at the Crow-Northern Cheyenne Service Unit. The establishment of a budget for the Billings Area Mental Health Program enabled real continuity to be a part of the initiation of Mental Health Programs as a separate Area service department. Both Billings Area and Dr. Carl Keener were uniquely fortunate in having had a realistic orientation to IHS and considerable experience in meeting Service Unit and tribal expectations, prior to assuming full time Area wide responsibility.

This continuity of service makes it a little difficult to recover any division of program development before and after formal establishment of a separate Mental Health Program. It was not, as in most other Areas, a new service to be added. In the Billings Area, Mental Health Services were already very much a part of the ongoing development of a program and point of view familiar to Billing Area staffs at many levels.

There was a shift in focus, however. Dr. Keener was now expected to extend his services and point of view to all seven Service Units. By travelling on a regular schedule, he was able to strengthen each local program in its own context and to plan for the addition and integration of additional staff. He extended the relationships with local agencies and Mental Health Centers and interested local personnel in becoming part-time consultants to the Flathead area, Wind River, and along the Highline reservations.

Dr. Keener particularly developed rapport with the schools, public, BIA, and parochial or mission, since it was his conviction that the emphasis of mental health, like that of other public health programs should be on children and youth as preventive programs rather than expending all of the program energies with adults whose problems were chronic and well entrenched. While not as ruthless as the dentists in setting arbitrary age cut off points for service, Dr. Keener was able to involve the Service Unit staffs in children's work for a greater proportion of their time than before. Significantly, he increased the level of concern of other agencies as he developed these consultations.

For example, St. Labre's Mission, which has a large installation at Ashland, just east of the Northern Cheyenne Reservation boundary, also has satellite day schools on the Crow Agency and a boarding school at Ashland for Indian children from elementary through high school. It also operates a jewelry factory and a sheltered workshop for Indian adult employment. St.Labre's was able to fill the need for a qualified psychologist for evaluation of school children by adding such a person to their staff to work with the Crow and the Northern Cheyenne.

One of Dr. Keener's strengths is his ability to talk frankly with tribal leaders and Indian parents who were caught in the cross-currents of intercultural stress. In discussing his former activities, he is able to articulate very clearly the transient and ephemeral nature of culture as it is experienced in contemporary living, in contrast with the static and idealized terms in which it is portrayed in anthropology, history and myth. He is able to point out that change is continuous, and has always been a part of the life and times of all people. This is especially true of the tribes in Montana and Wyoming, many of whom participated in the rapidly evolving culture of the Plains Indian after the introduction of horses and guns. It was only a few generations ago that their prior experience was that of gathering and hunting. This buffalo based culture represented a change from an agricultural tribal life. Dr. Keener sees very clearly that change cannot be prevented, but that the obligation of mental health professionals in working with the tribes is to help them understand the choices and options that confront them, and to explore with them the opportunities available to them. In this way, they can mark the course of changes for themselves and their children in ways to optimize potential -- a real mental health program is thus incorporated into the natural crises of cross-cultural stress. This point of view enabled him to establish his leadership on a basis of confident explorations, appropriate interventions and cooperatively developed programs.

B. Expansion of Service Unit Staffing

In general, this pattern of growth in the Billings Area can be read from the list of personnel added during these years, and from the natural extrapolation of the fundamental activities of the years preceding the actual receipt of a mental health budget. The continuity of Dr. Keener's expanding role in the Area Office was not always transmitted at the local level. In addition to the Area Chief position funds were also available almost immediately for full-time staff at the Service Units. For instance, at Crow-Northern Cheyenne a psychiatrist was hired, and a Social Services vacancy was filled at the same time. There was some discontinuity introduced by this rapid expansion, since the new staff did not always receive an orientation that included the full story preceding consultative arrangements and tribal orientation. There was a tendency for each new full-time staff member to feel that the program was starting fresh with that appointment.

This attitude is reflected in the narrative report of their first quarter's activities prepared jointly by Mr. Larry Slaughter, MSW, and Mr. Bob St. Marie, psychologist. This report is given in full, not only as an example of this discontinuity and lack of historic consciousness, but also because it describes the expansion of services from a major emphasis on patients to one of concomitant community involvement.

REPORT ON MENTAL HEALTH ACTIVITIES
JULY THROUGH OCTOBER 1969

> Most of the first four months our time and energy was concentrated on the initial states of establishing a full-time mental health clinic on the Crow-Northern Cheyenne Reservations. Since the parameters of the population are in some respect different than previous populations we have dealt with, a great deal of our time was spent trying to get a cross-sectional overview of the social, economic, and psychological problems found on and surrounding the reservations. This was accomplished by routine orientation programs, meetings with numerous community organizations and agencies, attending state and local workshops, reviewing the literature, and, last but not least, sitting down informally and talking with the Indian and non-Indian people.
>
> We met with many organizations and agencies throughout the Crow and Northern Cheyenne Reservations in order to ascertain their knowledge, need, and desire for a mental health program, explain other mental health programs and what one might possibly do in this community, and offer our services.

The organizations were:

A) The Tribe
B) Law and Order
C) Bureau of Indian Affairs
D) Ministers and Pastors (on and off reservations)
E) Community Health Representatives
F) Hospital Nurses
G) Public Health Service Nurses
H) Public Health Service Physicians
I) Tribal Health, Welfare, and Education Committees
J) Headstart
K) County Welfare
L) VISTA
M) All school administrators and/or staff on and surrounding the reservations
N) Mental Retardation Committee
O) Community Action Programs
P) Special Education Administrators and Teachers
Q) Remedial Reading Teachers
R) Vocational Rehabilitation Center - Billings
S) Big Horn County Hospital Administrator

Many of these agencies, some with good success, have been invited over to the clinic building for informal coffee breaks and chats. (Andrew Russell, Sanitarian, has been outstanding in initiating significant contacts with tribal groups, organizations, and providing realistic consultation regarding effective methods of meeting and working with the Crow Indians.)

Besides getting acquainted with the agencies and the people, Mr. Slaughter and Mr. St. Marie shared the tasks of hiring and training a clinical secretary, moving into an office building, ordering appropriate materials, including tests, books, and professional journals.

Furthermore, we have begun to make good use of a number of psychological and psychiatric consultants. Barbara Siane, a psychiatric nurse and teacher from Sheridan, is now in the process of becoming familiar with the facets of the reservation and will be coming on a regular weekly basis. She is especially competent and interested in group work and her services will be used accordingly. Dr. Robertson, a psychiatrist from the Veterans Administration Hospital in Sheridan, has also made himself available on a weekly basis. He is presently accepting referrals from the PHS physicians and will be present for biweekly case conferences. Dr. Keener is at Crow Agency periodically where he is meeting with the local ministers, present at case conferences, and available for consultation and supervision.

Next, let us briefly mention some of the services the Mental Health Clinic is offering. Arrangements have been made with Law and Order to have young people who are suspected and/or accused of experimenting with various drugs (e.g. glue sniffing. paint spray and gasoline inhalation) to be referred to the Mental Health Clinic. Working closely with the Community Health Representatives, we hope to see the youth and his parents on a voluntary basis, but if this is impossible, the tribal judge will make it mandatory. Also, the tribal jailor has agreed to release prisoners on a voluntary basis to attend the local A.A. meetings.

Besides receiving referrals from Law and Order, many clients are referred by the PHS physicians, PHS nurses, BIA, schools, ministers, Headstart VISTA, Special education and other sources.

A problem we have been confronted with is excessive drinking on the reservation. We have had four organizational meetings for the purpose of exploring, discussing, and activating possible alcohol education, treatment, and rehabilitation programs. Our emphasis is on Indian participation. Again, the community health representatives deserve a great deal of credit for initiating and perpetuating such a program. We have already progressed to the point where we have a temporary chairman and temporary sub-committees responsible for acquiring information regarding such things as half-way houses, Crow Club, educational films, etc.

Another project being worked out at the present time is the viewing and discussing of mental health related films. These viewings will occur at 3:00 p.m. every Wednesday and invitations have been extended to most agencies and organizations as well as to the general public.

Since the school is an excellent place for a child with a behavioral disorder to be spotted and is often the causal factor for many disorders, they have been given a great deal of attention. All schools on and surrounding the Crow-Northern Cheyenne Reservations have received personal contact from both Mr. Slaughter and Mr. St. Marie and services have been discussed. They are aware that the Mental Health Clinic will offer services such as:

A) Testing and Evaluation
B) Consultations Regarding Learning and Emotional Problems
C) Educational and Prevention Services
D) Counseling and Psychotherapy
E) In-Service Training

Presently, many of the schools are taking advantage of many of these services.

C. Leaving the Area But Still an IHS Consultant

At the end of his two year term, Dr. Keener returned to Denver to secure more intensive personal training, especially a didactic analysis, and to teach at the University of Colorado Medical School. For a period of time he was able to continue the use of the IHS program as field placement for residents, until this was halted by the confusions over available federal funds characteristic of training programs all over the United States. He continues to be available as a consultant to IHS programs, particularly at Intermountain School and in the Aberdeen Area at Rapid City.

IV: DISCONTINUITY: JAMES GUSTAFSON, M.D., SECOND CHIEF OF M.H. PROGRAMS

When Dr. Keener left, the differentness of developmental history in the Billings Area Program from the other Area programs was not recognized at the national level. Local staff and consultants had a considerable reservoir of experience and Service Unit programs were in various stages of development. An Area-wide and unifying philosophy and methods of working had evolved. The long association with consultants, especially with the University of Colorado Medical School psychiatry program, had placed considerable emphasis on community consultative skills as well as developing competence in the "medical consult" or patient oriented direct psychiatric services. However, this model had not been made explicit as IHS policy at either the Area or National level in any document or in informal orientation of new personnel.

A glimpse already has been given of the discontinuities that appear at the Service Unit level when history is not transmitted. At the Area level, the lack of explicit directives and structure also produced confusions when there were several staff changes simultaneously.

A. Two Chiefs At Once

Two persons were hired at the Area Office level as Dr. Keener left, but neither felt that he had clear directives or structure within which to work. Many Area Office staff assumed that Margene Tower (Dohner*), R.N.,M.S., who was recruited from Denver, would act as Area Chief of Mental Health Program and continue the established pattern, in which she had been trained and had accumulated considerable experience in non-IHS settings.

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* Miss Tower was married to the Area Chief of Medical Services, V. Alden Dohner, M.D. They were divorced and she has assumed her maiden name.

At the same time Dr. James Gustafson, having completed his residency in psychiatry at Ann Arbor, Michigan, became available for assignment to IHS from the pool of draft deferred psychiatrists. He too reported in 1971 to the Billings Area, with the assumption that he was to be Chief of the Area Mental Health Programs. The local Area director and his staff reviewed both persons' qualifications and made an official decision to appoint Dr. Gustafson as Chief fairly promptly. However, the two Mental Health Program personnel continued to compete with one another over this issue for another year. Between the too many issues of "chauvinism," involving M.D./R.N. relationships and male/female status, at times consumed a great deal of energy and attention. The lack of prior IHS experience on both their parts often made bureaucratic processes more mystifying than they need have been.

Dr. Gustafson's and Ms. Tower's appointments introduced new ideas, and sometimes abrasive concepts, into the former steady, almost deceptively calm expansion of the Mental Health and Social Services programs which had characterized the preceding ten years. Discontinuity was inevitably introduced into the system as these two staff members lacked the historical perspective and apparently did not receive or absorb an orientation which enabled them to integrate easily with past program developments. Staff at all levels attempted to adapt to the new Area Office Mental Health Program staff, and as can be seen in the material that follows, both contributed to expanding and developing services.

B. A New Model of Service Standards and Delivery Attempted

Dr. Gustafson had an excellent background in teaching through the A.K. Rice Institute, but his classes were made up of people who met together by their own choice for brief intensive experiences, and then separated to make applications independently. This did not give him background in the day-to-day continuity needed to cope with and change the irrational forces which he sensitively noticed in his new assignment. Neither had he had long term experience as a community consultant, nor with frames of reference for therapy such that he could adapt concepts such as community outreach into the therapeutic framework. It appears from his comments that he tended to see outreach and follow-up as equivalent to proselytizing religiously or using moral suasion efforts to interrupt self-destructive behavior patterns.

His prior experience gave Dr. Gustafson a sensitivity to the feelings of in group and out group that developed around many levels of IHS Service Delivery. In an attempt to share his knowledge and utilize his skills, he held a Workshop in Billings for Indian Mental Health staff and some of the professional consultants using the Tavistock model and hoping to focus on interpersonal process and their distortion by authoritative roles. Although a number of the Indian participants have commented that they learned a good deal from the experience, their reactions and sense of ability to change habitual practices seemed negligible.
Dr. Gustafson summarizes his own observations of this workshop quite candidly in one of his reports to the Area Director. This report seems worth quoting because it describes vividly problems in communication and relationship which are commonly experienced throughout IHS. In fact, they

are one of the crucial difficulties facing any system in which the power structure representatives are in the numerical minority, charged with using their unique expertise to establish contextual relationships with a population that has a social and emotional minority position, but is actually numerically larger.

The excerpt below is from Dr. Gustafson's report as Chief of Mental Health Programs to the Area Director, Billings, October, 1971:

> 2. Innovations:
>
> a. Group Relations Conference: This was the first group relations conference in this area, which was co-sponsored by the Billings Area Indian Health Service and the Indian Community Action Program and held October 4-5, 1971, at the Area Office. Its principles and methods are those developed in the Center for Applied Social Research staff of the Tavistock Institute of London and developed in this country under the leadership of the Washington School of Psychiatry. The primary task of the conference was to provide the members with opportunities to learn about the nature of authority and the interpersonal and group problems encountered in its exercise. Members participating were four persons from Indian Health Service in this area, four persons from Indian Community Action Program, and two persons from the Northern Cheyenne Community Action Program. From the perspectives of the consultants, a number of important issues emerged:
>
> a. There was considerable expectation that the technical knowledge of the consultant would be sufficient to dictate to the members what they should be doing from moment to moment in order to learn. This expectation seemed to be a double edged sword, in that it tended to demean the members and elevate the consultant to an impossibly difficult role. One of the members later referred to this as the expectation that he would "walk on water." Another consequence of this expectation about the technical ability of the consultant was that this ability would be used to experiment on and humiliate the Indian membership. This level of mistrust makes it extremely difficult for members to proceed with the work of learning.

b. Cohesion for the work of learning did not occur in the membership until there was some feeling of mutual opposition to the consultant. This seemed to be possible only when he was not present in the room.

c. It was noted repeatedly that any support by the Anglo consultants for the work of an individual Indian group member made that individual unable to continue as the work leader of the group.

It is assumed by the consultants that these processes brought out in the laboratory situation of the group relations conference are operative daily in the work between technical experts at the reservation and those persons whom they are attempting to serve. What is not yet clear from the conference is not what the consultants thought they learned from the conference but what the members learned. The emotional climate of the conference was so difficult and strained at times that learning seemed too painful to be possible. The detachment of the consultants which had made their learning about the conference possible certainly wasn't available to the members for whom problems of authority are intense daily issues.

Subsequent monthly reports indicate that Dr. Gustafson had an opportunity to observe the National Training Laboratories staff in a series of training exercises, which seemed to have his goals in mind, but which utilized much less personally threatening processes to involve the conference participants. There is evidence that he made some attempt to locate National Training staff to develop such workshops in the Billings Area. Apparently, however, this was not successful. One can gain a fair amount of empathy for him as someone who saw the dimensions of a problem, but found no tools with which to solve it. It is apparent that these feelings are not uniquely his from the comments of many staff, both within and outside Mental Health who have left IHS in frustration and disappointment, or who have settled for less than they had hoped to accomplish in their IHS roles. However, Dr. Gustafson is more frank and more incisive in his description of the dilemmas he faced than most persons working in the stressful arena of cross cultural relationships.

There are, of course, personal factors which enter into the development of programs and roles. There was real difficulty in Dr. Gustafson's ability to come to grips with his administrative role, as differentiated from a consultation role. Although he had had hospital experience, most of the significant experience involving his own responsibility was in situations where his loyalty and relationships were with a department of psychiatry, which also provided him with support systems. Even in its dealing with internal theoretical differences, the psychiatric system provided roles and models unlike paramilitary, bureaucratic, and health system models within which he needed to function in IHS.

For approximately 18 months of his two years Dr. Gustafson struggled with these new, to him, situations within the IHS system, and spent much of his energy trying to change IHS rather than developing community and service unit programs, or being maximally available as a staff resource to community personnel. This struggle essentially blinded him to perceptions of the long history of interdisciplinary work and development in the field community mental health programs. His predisposition and prior learning also sensitized him so that he heard the complaints and the dissident expressions wherever he went, but seldom elicited positive comments.

C. Status and Power Struggles Mirrored in the Service Units

Some of this battle within the system was exacerbated by the fact that both Dr. Gustafson and Mrs. Dohner had arrived assuming that they were appointed Chief of the Mental Health Program. Almost mirroring the dual lines which resulted in two Chiefs being appointed, the entanged threads of line and staff authority caused dissension within the Area and Mental Health Program staff in each Service Unit.

This confusion is often easily exacerbated by lack of experience with line and staff organization models on the part of consultants. Although the Mental Health Programs chiefs have a major responsibility to recruit staff and to recommend allocation of funds, as well as to establish training programs and provide technical (clinical) supervision, they are not line administrators. The Service Unit Director has this authority and is responsible for personnel regulations and the administrative operation of the Service Units. This remains somewhat of an issue when the Mental Health budget is a line item appropriation, handled at the Federal level, and there are differences in philosophy or personnel and activity regulations which clash between the two. The aim of the Area Director during this period was to develop a comprehensive care team, of which Mental Health services were a part. Not all Service Unit directors interpreted this in the same fashion, and tensions affected both local and Area Mental Health staff.

Since with Mental Health, as with several other categories of funds, the monies are not interchangeable at the local level, it was sometimes felt that Mental Health was taking unfair advantage (or a share to which they were not entitled) when other activities felt a constraint because of reduced Area travel funds, as an example. The degree of freedom allowed in the control of Mental Health funds could seem to SUD's to be a luxury or laxness, when to the Area director and Area Mental Health staff, these activities seemed essential to the effective operation of the program. As a result, there were often conflicting directives which caught local staff in a double bind. For instance, at the same time that a Mental Health Worker might have been working at crisis intervention with a family unit quite late at night, the SUD might require all hands to report at 7:45 a.m. or forfeit part or all of a day's pay.

After considerable whipsawing back and forth, these issues were settled with Dr. Gustafson accepting that Service Unit personnel were under administrative supervision of the SUD. He limited his role to that of a psychiatric consultant and technical advisor, interpreting the Area Mental Health Chief's role as a purely staff function and renouncing all line authority.

Dr. Gustafson's final resolution of his role occurred in the last half year of his tour of duty, and he observed that he felt much easier in his work with the various staffs knowing that they no longer had to be defensive about administrative matters on his calls. Only future developments can tell if his choices were wise ones, or merely fitted the personalities in Billings at that point in time.

D. Educational Network Developed

One of Dr. Gustafson's contributions to Billings Area Health Programs was the development of an education and training network. Under this scheme funds were credited to each staff member for the purchase of training and materials. An exchange of ideas, resources, and pooling of funds to secure speakers was encouraged, although individuals could choose to use their funds for individual academic training if they wished and if the funds were sufficient.

In order to operate effectively, this system required that current information about staff skills and interests be circulated frequently, since it would be most economical to organize exchanges of expertise within the "network" of IHS staff. Funds were also stretched further by sharing films, books, and other training materials. This created a need for developing and circulating catalogues of these items as they might be available in IHS offices or from schools, colleges, other federal agencies, and even in tribal projects or libraries.

The cooperative exchanges, it was hoped, would lead to a sharing of problems and of mutual efforts at solutions. It is not clear whether the Area wide training format that can be meaningfully evolved in this way will be sufficient to take care of all in-service and career mobility needs. However, the stimulation of exchanges has been fruitful in many ways, and has potential yet to be realized.

V. EFFORTS TO RESTORE STABILITY:
MARGENE TOWER (DOHNER), R.N., M.S.

In resolving their own status struggles, the two Area Consultants, James Gustafson, M.D., and Margene Tower, R.N., M.S., divided task responsibility and to some extent concentrated their efforts on different geographic sectors. Ms. Tower focused her attention on the Flathead and the "Highline" Reservations and assumed responsibility for developing alcoholism programs and for recruiting personnel.

Dr. Gustafson left IHS in 1973 at the end of his two year obligation, and Ms. Tower was designated Chief of the Billings Area Mental Health Programs. Since the activities programs and models which she developed earlier are now being extended to the whole Area, it seems most logical to describe them without artificially separating the time period involved.

A. Alcoholism Program Development

1. Flathead Detoxification-Crisis Unit Contract

A model now being utilized as a guide on all reservations was first developed on the Flathead Reservation. Since alcoholism programs are funded by quite different agencies than IHS and are in general tribally operated, the role for IHS Mental Health staff is often both ambiguously defined and ambivalently supported. Ms. Tower developed a way of making roles and functions negotiable by utilizing contracts with the Flathead Tribal Programs and with a local hospital to provide a Detoxification and Crisis Center.

This resulted in an integrated set of services developed during the processes of meeting together, planning, disagreeing, negotiating and finally cooperatively solving problems. This use of contracts strikes a better balance between the factors of power, expertise and minority-majority cultures, so well described by Dr. Gustafson as typical of traditional federal service delivery systems.

As a result of these negotiations a four-bed unit (with an additional four beds for emergency use) is provided by a privately operated Ronan hospital. This space was made available for detoxification and crisis hospitalization of persons who were abusing the use of alcohol. It can also be put to other uses with the mutual decision of the Tribal Program, hospital staff and IHS.

Budget increases in the summer of 1972 permitted the addition of another psychiatrist, and James Newman, M.D., was assigned to the Flathead Reservation. He provided psychiatric back-up for the physicians and nurses at the hospital-based Detoxification Unit. Through discussions with both hospital and alcoholism counselor staff he is involved in the management and follow-up for individual patients, negotiating procedural and administrative issues, and the training of both staffs in the fields of alcoholism and crisis intervention.

The hospital staff meets with Dr. Newman on a regular basis for consultation about the management of this program as well as for consultation about the other patients, Indian and non-Indian, that they may wish to discuss with a psychiatric consultant. The resulting flexibility of programming is such that the detoxification unit is used as an adjunct to the tribal halfway house and to serve many needs besides the strict detoxification process under medical supervision. Family visits and family therapy are frequently scheduled making use of the hospital space, and in some instances multiple family sessions are held.

Dr. Newman has broadened community involvement by emphasizing the development of an Alcoholism Board and through his other activities on the Reservation.

2. Fort Peck Rehabilitation Services

In developing a complete range of alcoholism services, the Assinboine and Dakota Sioux at Fort Peck discovered a gap in conventional planning. After detoxification and after sobriety is achieved through sheltered living in a halfway house, urban programs usually expect their clientele to find suitable employment and become self supporting. In this remote area and with this population, an intermediate step seemed advisable. What evolved was a midpoint between the halfway house and full employment.

This was accomplished by establishing a tribally owned Thrift Shop which is staffed by recovering alcoholics. While clients are developing skills and work tolerance, they are available for counseling and social services and are earning some funds for themselves. Consultation and back-up medical services are provided by IHS, but the responsibility for program administration and operation, including initiative and decision making, remains with the tribe and its own program staff.

IHS involvement in this project has been channeled through the development of an appropriate contract with the Fort Peck Tribal Government. The same benefits of becoming involved in processes of problem solving, while retaining autonomy and mutual respect, have been evident. This replication demonstrates the usefulness of contracts as a tool for developing Mental Health programs. There is strong commitment to utilizing this contracting model with other tribes, some of whom may also utilize a variation of the specific services involved.

B. A.A. Degree in Human Services Contract

The Educational Network introduced by Dr. Gustafson provided for specific skill development but was really designed to supplement basic training already acquired. In many ways it seems more suitable for professionals than for the increasing number of paraprofessionals in the Billings Area.

Each Area Mental Health Program in IHS is involved in recruiting, selecting and training local tribal persons to serve as paraprofessional staff. Only in the summer of 1973 has there been an attempt to develop a servuce wide career ladder, with job descriptions and requirements. Until then, and even with the broad descriptive statements being considered, the specific tasks assigned and skills to be developed have been organized in each Area according to local needs and resources.

In the Billings Area Ms. Tower has consistently conceptualized the Mental Health Worker as a human services specialist, with broad consulting advocacy, and counseling skills. Job specific skills can be developed upon this base which will enable local Indian people to develop career mobility within IHS and by lateral movement to other agencies. Some who may desire to complete Bachelor's degrees and even professional training will be able to build on this academic foundation.

A basic formal education is often needed as a foundation for this mobility and to provide a context for skill application. This is especially true of Mental Health workers who often must work independently, in crisis situations, and as liaison persons between their communities and the professional staff.

IHS maintains a training facility in Arizona - The Desert Willow Training Center - which among its offerings includes a training course for Mental Health workers which combines courses at the Arizona facility with supervised experience. Through special arrangements IHS students can earn an Associate Arts degree. However, the courses must be quite general to accommodate trainees from many locales. A more serious problem involves the required lengthy absence from home and job - both of which are expensive in cash and emotional strain.

For these reasons Ms. Tower and her staff have negotiated a contract with Rocky Mountain College in Billings for a program leading to an AA degree in Human Services. At present (1974) only Mental Health workers are enrolled, but it is designed to include Alcoholism counselors, Social Work aides, and other paraprofessionals as well. The basic core of liberal arts courses (English, History, Science, etc.) and the specialty mental health courses are essentially similar to the Desert Willow Training Center curriculum. However, a study of alcoholism is included in the general Mental Health curriculum at Rocky Mountain to reflect local Service Unit needs.

IHS staff provide some of the specialty courses and full supervision. There seems to be an excellent working relationship between the Rocky Mountain College faculty and the IHS staff, who collaborate in designing relevant courses and coordinating administrative matters. This arrangement, supplemented by student input, ensures an overall understanding of Indian needs and problems, and a realistic continuity of work and study.

The students seem enthusiastic and by the end of the summer session of 1974 should have all earned half of the credit units needed for their

AA degrees. This is being accomplished without damaging disruptions of home life or work assignments. The high morale of the students and their motivation to learn impress the faculty and are reflected throughout the program.

C. Decentralized Deployment of Staff

1. Operating Plan Fiscal Year 1974

As has been indicated, Dr. Gustafson felt that his role as a consultant to the Billings Area Mental Health staff was seriously compromised by their perception of him as a "boss" and also by his own discomfort in dealing simultaneously with training issues and administrative ones. Together with Ms. Tower he developed a plan whereby administrative authority could be devolved to the Service Unit Directors for "line" authority decisions and Area Office Mental Health staff would retain "staff" responsibilities. It was further felt that peer review, rather than professional judgment of paraprofessionals and Area office review of Service Unit staffs would be a healthy direction in which to move.

Accordingly, these concepts were implemented in an Operating Plan promulgated May 15, 1973, to become fully implemented by the beginning of the fiscal year July 1st. This plan is presented in full as it was circulated to all Service Units and to the Area Office staff at that time.

The evaluation reports and peer reviews called for in this plan have not been scheduled or completed before the cut-off date of this report, and consequently cannot be incorporated at this time. However, evaluation of this plan should be of considerable interest to many other Areas who face similar problems of entangled and enmeshed relationships in carrying out both line and staff functions within one set of staff. The IHS Mental Health Programs have a relative autonomy built into their operations by virtue of the fact that up to the present the budgets for mental health activities are separately appropriated and not a part of the general operating Area Budget . This issue is not made clear in the Operating Plan nor in discussions held with Dr. Gustafson and Ms. Tower but may seriously become involved in the implementation of this method of decentralizing Mental Health Programs.

OPERATING PLAN, F.Y. 1974
Billings Area, IHS

Plan Title: Decentralization of Mental Health Programs
Project Director: Chief, Area Mental Health Services Branch
Objective:

To delegate authority for Mental Health Programs to all the Service Units in the Billings Area.

JUSTIFICATION AND APPROACH

There is considerable unresolved disagreement in the Area as to what "mental health" tasks and what methods are primary. In the absence of a common task and method, there is not a good way to govern the system from the Area Office. If the Area then attempts to dictate to the field, the Service Unit Mental Health staff often have a contradictory double line of authority over them.

Therefore, we plan to use the following approach during Fiscal Year 1974, which has been informally tested for the past six months:

1. Each Service Unit Director, or representative of the SUD, will be responsible for defining the tasks of the program at his Service Unit with the help of his Mental Health staff and then to see that these are carried out.

2. The Area Chief and Deputy Chief of Mental Health Services will make themselves available to consult to the SUD and field Mental Health staff.

3. The Educational Network will be continued, including delegation of funds to the Service Units for in-service education.

4. Each Service Unit Mental Health program will be evaluated at least once a year by peers from other Service Units.

STANDARDS

Each Service Unit Director, or representative of the SUD, will see that the following are maintained:

1. Legally adequate patient care records.

2. The Mental Health reporting system of patient contacts and project contacts.

3. The suicide reporting system.

4. Quarterly reports that summarize larger issues beyond the detailed Mental Health reporting system.

EVALUATION CRITERIA & PROCEDURES

The following criteria will be used to determine decentralization program impact:

--to be judged by the peer evaluators:

1. What is the quality of the clinical work (in the light of the stated goals of the Service Unit)?

2. How are the staff used by the people? What patterns of use? What kinds of patients and problems?

3. What benefits have come from the special projects?

4. Do other PHS staff in the Service Unit find the consultation of the Mental Health staff useful (CHR's, physicians, etc.)?

--to be judged by the Chief, Area Mental Health Services Branch:

1. Is the offered consultation of the Chief of Mental Health Services used more frequently and in-depth than before decentralization?

2. What educational experiences have field staff had through the educational network? Have they initiated these themselves?

--to be judged by the Area Director:

1. Do the Service Unit Directors understand their Mental Health programs, the tasks, the results?

2. What changes are they making as a result of the peer evaluation? Area Mental Health consultation? Educational network? Clear authority resting with themselves?

--to be judged by Service Unit Mental Health staff:

1. Have field staff learned more about program strengths and weaknesses from peer evaluators than from previous trip reports of Area Mental Health staff?

2. How useful has the consultation of the Area Mental Health staff been, compared to before the decentralization? What actions have Service Unit staff taken as a result of the consultation?

3. How useful has the Educational Network been to the Service Unit Mental Health staff? What differences has it made for clinical work and projects?

4. Is the morale of Service Unit Mental Health staff better since decentralization?

DATA NEEDED

--by peer evaluators:

1. The Mental Health reporting system data on all patient contacts and project contacts--with appended clinical notes and project summaries.

2. Quarterly narrative reports.

3. Direct discussions with field staff about the foregoing materials.

4. Chief, Area Mental Health Services Branch will be making other recommendations of materials and issues to consider.

5. Peer evaluators will be free to make their own requests for additional data.

--by Chief, Area Mental Health Services Branch:

1. Comparison of experience before and after decentralization.

2. Review of committment registers from Educational Network.

--by Area Director:

1. Reports of peer evaluators.

2. Reports of Chief, Area Mental Health Services Branch.

3. Direct discussion with Service Unit Directors and Mental Health staff as needed.

--by Service Unit Mental Health Staff:

1. Comparison of experience before and after decentralization, with special reference to:

    a. Peer evaluation.
    b. Area Mental Health consultation.
    c. Educational Network versus previous Area in-service education.
    d. Supervision at the Service Unit versus from the Area and Service Unit.

OPERATING PLAN, F.Y. 1974

Billings Area, IHS

Plan Title: Decentralization of Mental Health Programs
Project Director: Chief, Area Mental Health Services Branch
Objective(s):

To delegate authority for Mental Health Programs to all the Service Units in the Billings Area.

Milestones	J	A	S	O	N	D	J	F	M	A	M
	Completion Date										
1. Consultation to all Service Unit Directors or representatives with regard to: a. task definitions, and b. maintaining the minimum records and reporting.					△						
2. Useful considerations outlined by Chief, Area Mental Health Services Branch for peer evaluators. Evaluators are to be named for each Service Unit by the Chief, Area Mental Health Services Branch.						△					
3. Peer evaluation of all Service Unit Mental Health Programs completed. Reports to respective Service Unit Directors and Area Chief of the Mental Health program, OCHS, and OAD.								△			
4. Review of Service Unit Director's direction of his mental health program in Area Director's Service Unit Director Performance Review.									△		
5. Service Unit Mental Health staff complete reports to the Chief, Area Mental Health Services Branch concerning their judgments of the decentralization.											

2. Professional Staff Deployment

As Mental Health Programs have developed in most Areas, there is a maturational stage at which decisions have to be made about the deployment of professional personnel. Usually a small team has worked initially from the Area Office. Then, as staff increases and as activity demands rise, the possibility of shifting one or more professional assignments to the more distant Service Units seems logical.

In the Billings Area decentralized deployment of professional staff has been characteristic from the beginning. During the early years the utilization of local contract consultants established programs and initiated staff development at widely scattered points. Dr. Keener, as the first budgeted Chief of Mental Health Programs, extended his range to include all Service Units. The two professionals, Ms. Tower and Dr. Gustafson, found some mutual support in joint planning but agreed that additional psychiatrists and other professionals should be assigned to the Service Units rather than the Area Office.

Where consultant contracts were in effect, as on the Crow and Northern Cheyenne Reservations, personnel hired by IHS supplemented the consultant by filling the expertise represented by other disciplines. An attempt to provide a psychiatrist located at Browning to serve the Blackfeet Reservation and also to consult with the other "High Line" Reservations was made in the summer of 1973. A psychologist, John Iacovini, had been assigned to Fort Peck for two years and had lent some support to the social worker at Fort Belknap and Rocky Boy's, but he left IHS in 1973. However, the psychiatrist just out of residency, recruited for the Browning position, was uncomfortable with the isolation of the post. Even after an attempt was made to develop a base for him at the Area office in Billings, he elected to take advantage of the cessation of the physician's draft obligation and left IHS service after a few months.

An experienced MSW, Mr. Fred Muhs, transferred from Alaska to Browning to attempt this development of consultation resources as well as to replace the psychologists who had been in Fort Peck and Browning for a number of years but who had left IHS at about this time. It was hoped that Mr. Muhs, as an experienced pilot, would be able to utilize a small plane as an aid to visiting the other reservations. However, safe flying days during the winter are fewer in Montana than Alaska. This phenomenon has delayed his contact with other reservations except the Flathead Reservation which can be reached easily by telephone and car throughout most of the year.

There had been a psychologist from the local CMHC in actual contact with the Flathead Reservation population, and the social worker there had taken an active role in developing mental health resources. In the summer of 1972, Dr. James Newman was assigned to the Flathead Reservation and developed a wide base of contractual and consulting relationships in the surrounding communities and with tribal leadership.

3. Increase in Number of Mental Health Workers

The goal of the Area has been to provide not only professional personnel to each unit but also to involve each tribal group in the selection and utilization of paraprofessional staff as well.Mental Health workers are now available at almost all the Reservations (see staff list). In some few instances there is discussion of the need for more than one such staff member and even the effort to recruit and employ a second Mental Health Worker. Up to December 1973 this most often occurs where two Tribes are administratively connected by a single IHS Service Unit as at Rocky Boy-Fort Belknap, Crow-Northern Cheyenne, and the Shoshone-Arapahoe Wind River.

The number of paraprofessionals working closely with Mental Health Programs is augmented by Tribal activities, such as Public Service Career grants and Alcoholism Programs.Mental Health Programs provide supervision and back-up services to tribal Alcoholism Counselors, under the contracts already described, and also to Social Service Associates who may work cooperatively between the Mental Health and Social Service Branches.

As Mental Health Workers became available, they were often unclear about their roles, to whom they were responsible for duty assignments, hours, and other details. As already indicated, Dr. Gustafson arranged for these details to be separated from Area Mental Health Staff consultative functions acknowledging the administrative line responsibility of the Service Unit Directors. This left negotiations about roles, functions, duties and schedules at the Service Unit Level. Where full time Mental Health Program professionals are available, the supervision of administrative details is still sometimes delegated back to them, but not always. In at least one instance the dissonance generated reportedly became the final motivation for a Mental Health worker to take a leave of absence and earn a Master's degree.

In spite of these problems, the general dedication of the Mental Health workers recruited has been outstanding. Many of them are more mature persons of their tribes and veterans of bureaucratic red tape battles in other agencies. Most of them are anxious to develop their skills and see a key role for themselves and others like themselves in developing programs and supplying much needed counselling and supportive help to the individuals and families of their reservations. As they write monthly reports, some of their endurance, determination and humor is reflected in comments usually under the topic heading of "Problems, new or recurrent...". A few of these comments are quoted in the descriptions of individual Service Units that follow. This seemed the best way to give the flavor of the work of this part of the staff and to recognize that they are as much a part of the Mental Health Programs as the professionals who have been described and discussed at greater length.

4. Comments

In general, the program in the Billings Area was so decentralized from 1971 to 1973 that often professional staff and consultants, as well as Mental Health Workers, from one part of the Area had no opportunity to meet and know one another as colleagues or to compare developments in their programs. However, the Peer Review and Ms. Tower's ability to hold some Area staff meetings has begun to counter this centrifugal force. In addition, the training program for Mental Health Workers is beginning to build a group feeling and develop a sense of common tasks.

In contrast with the other Areas, decentralization of staff has not been a growth crisis for the Billings Area. Some centralizing and group identity problems have existed, but these are being resolved in a practical fashion. The Area has adopted a goal of staffing for each reservation which would provide one professional and one paraprofessional Mental Health worker. Budget and recruitment obstacles to achieve this goal are being consistently attacked.

VI. CURRENT STATUS OF SERVICE UNIT PROGRAMS 1973

A. Introduction

The following reports present a picture of the evolution of the Mental Health Programs on each of the Reservations. While Crow-Northern Cheyenne and Rocky Boys-Fort Belknap Reservations were each administered by a single Service Unit, the differences and distances involved have led to the establishment of separate programs. The Intermountain School is also described briefly.

A uniform order of presentation is followed for each program. The initial sheet is a map of the Reservation, followed by details of its geography, population and tribal characteristics excerpted from the Service Unit Profiles Prepared and kept current by Mr. Harvey Lich in the Area Office of Program Planning and Evaluation. These booklets are best described from the Preface prepared by Dr. Lewis Patrie, Billings Area Director until June 30, 1973.

> "The Service Unit Profile information gathered from many sources presents a general cross-section of the Indian people within the Service Unit, their Reservation environment, and some of the services that they receive. This document should be useful for providing information to persons and agencies unfamiliar with Indian Health Service programs, for providing orientation information to incoming Indian Health Service personnel, and for providing a thread of health program continuity from year to year."

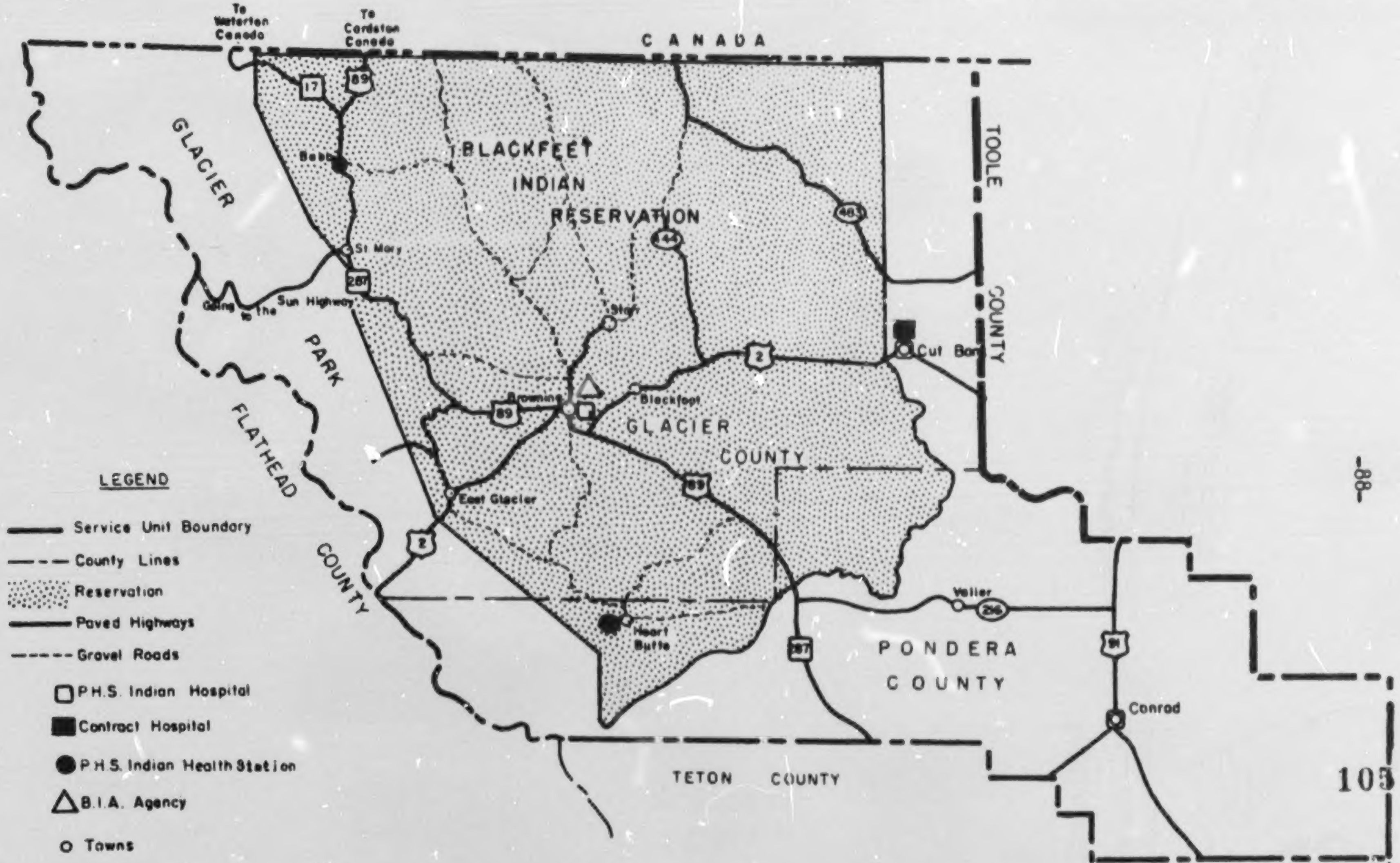
Following the introduction, a narrative account reports the evolution of the Mental Health programs from their beginnings to the winter of 1973. Source materials, such as monthly and quarterly reports, are quoted whenever appropriate in order that the flavor and texture of each program can be most directly conveyed.

In those instances where portions of the Reservation programs have been used for illustrative purposes in prior sections this material is cross referenced but not duplicated in this section.

B. Individual Program Descriptions

1. Blackfeet Reservation

BLACKFEET SERVICE UNIT


To Waterton Canada
To Cardston Canada
CANADA
17
89
Babb
BLACKFEET INDIAN RESERVATION
444
464
TOOLE COUNTY
GLACIER
St Mary
287
Going to the Sun Highway
PARK
Star
Cut Bank
2
Browning
89
Blackfoot
GLACIER COUNTY
FLATHEAD COUNTY
East Glacier
2
89
Valier
296
91
Heart Butte
287
PONDERA COUNTY
Conrad
TETON COUNTY
LEGEND
Service Unit Boundary
County Lines
Reservation
Paved Highways
Gravel Roads
P.H.S. Indian Hospital
Contract Hospital
P.H.S. Indian Health Station
B.I.A. Agency
Towns

Blackfeet Tribal Business Council
Location: Browning, Montana

Rev. 1-19-73

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
BLACKFEET SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			GLACIER			PONDERA		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	668	347	321	596	317	279	72	30	42
5-14	1709	831	878	1521	742	779	188	89	99
15-24	827	385	442	732	333	399	95	52	43
25-34	561	256	305	515	238	277	46	18	28
35-44	455	226	229	391	191	200	64	35	29
45-54	372	193	179	342	184	158	30	9	21
55-64	287	151	136	256	127	129	31	24	7
65+	287	135	152	262	121	141	25	14	11
TOTAL	5166	2524	2642	4615	2253	2362	551	271	280

---

* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

1. GEOGRAPHY:

The Blackfeet Reservation is located in North Central Montana and occupies an area of about 1,500,000 acres. Most of the reservation is in Glacier County but a small part is in Pondera County. It is bounded on the west by Glacier National Park, on the south by Birch Creek, on the east by Birch and Cut Bank Creeks, and on the north by Canada. The general topography is a rolling plain rising westward to the Continental Divide. The average elevation ranges from 3,800 to 5,000 feet, excluding high mountain peaks.

The reservation has cold, relatively dry winters and fairly warm summers with a pronounced "wet" season in May and June. The weather extremes are more severe in the western part of the reservation as compared to the eastern part. Average rainfall ranges from 32 inches in the west to 11.44 inches in the east. Average frost free days vary from 80 days in the west to 120 days in the east. Temperatures vary from extremes of -56 degrees in the winter to 99 degrees in the summer. The mean January temperature is 18 degrees and the mean July temperature is 62 degrees.

Browning is the seat of tribal government as well as the major trade center for the reservation. Cut Bank, the county seat of Glacier County, serves the eastern edge of the reservation. Great Falls is the nearest major shopping center. Kalispell, 100 miles to the west and Havre, 160 miles to the east serve the reservation to a lesser extent. Cardston, Alberta, Canada, 15 miles north of the reservation, serves the northwestern part. The principal villages and settlements on the reservation besides Browning are: East Glacier Park, St. Mary's, Babb, Blackfoot, Starr School, and Heart Butte.

2. POPULATION:

There are approximately 10,800 enrolled members of the Blackfeet Tribe.* Of these estimated 5,750 Indians living on the reservation, approximately one-half live in Browning. The population on the reservation is increasing somewhat due to new employment opportunities. Four-hundred-seventy-five Indians live adjacent to the reservation. Refer to population table for age and sex breakdown, page 89.

3. TOTAL UTILITIES ON RESERVATION:

Eight hundred and fifty-five reservation homes have acceptable water facilities and 145 do not. Over 700 of the homes have adequate sewage disposal facilities. Homes without adequate water and waste facilities will be covered in future housing or P.L. 86-121 Programs.

Ninety percent of the reservation homes have electricity.

Natural gas is available to most residents of Browning and East Glacier.

*The 1970 Census (projected by Headquarters) shows an estimated population of 5,166 for the Blackfeet Service Unit; however, Tribal, CAP, BIA, and IHS estimate the Indian population as 5,750.

Dr. Robert Coe Eddy has served as a part-time psychiatric consultant to this Service Unit for many years. One of his early descriptions of his activities is quoted in this report pp. 41-45.

A psychologist, Blaine Wassecha, PhD., was added around 1970 and functioned as a full time Mental Health staff person until the summer of 1973. His activities are described in the Service Unit Profile as follows:

> The Psychologist serves as a mental health resource person. Indirect patient services and consultation is available for community-wide agencies. Direct services are provided inpatients and clients. Psychological consultation is an important aspect of facilitating patient's medical therapy. Referrals are accepted from the physician's and community groups. The auxiliary medical staff refers clients with mild reactions for treatment in an effort to give preventative health. Research and consultation for supportive staff are secondary activities.
>
> Mental health emphasizes prevention as the guiding principal for services. Preventative intervention is the treatment mode which catalyzes treatment of acute emotional reactions.
>
> Major problems requiring mental services are: non-functional and functional reactions associated with family crisis, financial distress, emotional problems, suicide gestures, alcohol related problems, and the despair of poverty conditions.
>
> Lesser problem areas are family planning, problem pregnancies, maternal and child care and unwanted or neglected children.
>
> Consult to community agencies facilitates development of treatment programs, especially, directed toward fostering community mental health practices.

In 1972 a Social Worker was placed by the Social Services Branch at Browning, and his activities are also described in the Service Unit Profile.

> The Social Worker is responsible for consultation with doctors and paramedical personnel regarding alcoholic patient problems, suicide attempts, marital problems, children with emotional problems, abandoned children, unmarried mothers and patients needing financial assistance, or nursing home care. This one-man department coordinates hospital social services with BIA social services, Montana State social welfare and rehab agencies, and veteran facilities in and out of the state. The social worker also acts as a client advocate and referral agent on behalf of patients unable to secure benefits by themselves. He also seeks resources for CMC patients and supervises social work students or placement from the University of Montana whenever one is placed here.

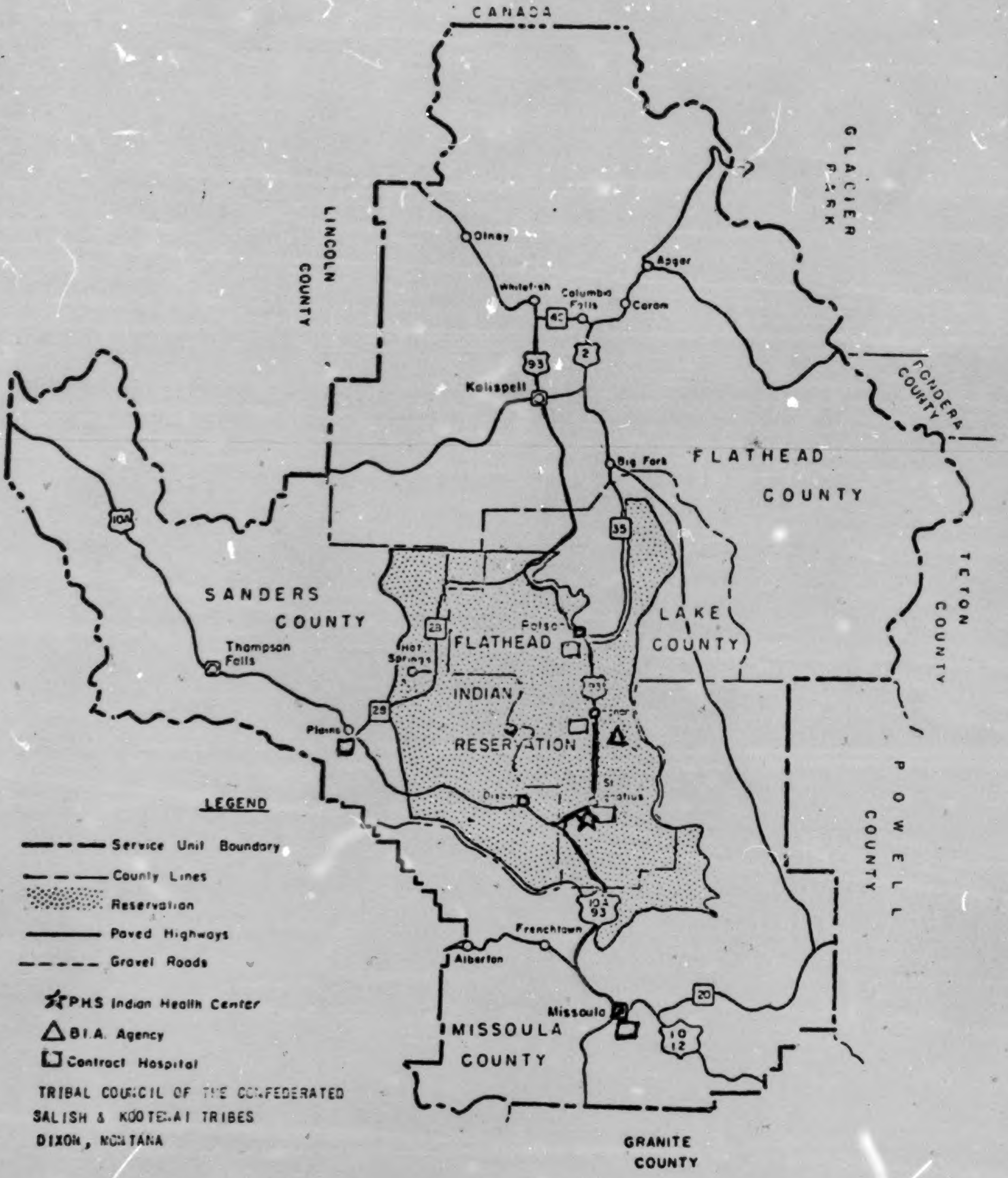
In the winter of 1973, Fred Muhs, M.S.W., transferred to this post and has not had time as yet to establish his own additions to this program. However, he has made efforts to coordinate with the Social Services branch as well as the consulting psychiatrist so that a team can evolve to further develop an integrated program.

The Service Unit Director's position is described as that of a "program manager," who actively meets with the Tribal Council, Community boards and health agencies, as well as with his own staff. The Mental Health Program staff work to develop rapport with many of the same agencies and extend their services at the preventive level.

It might be noted that Mr. Muhs has developed a collaborative exchange with the Flathead Mental Health staff, and it is hoped that he will be able to extend his relationships to Rocky Boys and Fort Belknap in the spring of 1974. This will provide additional resources for the Highline Reservations and help develop coordinated programs.

2. Flathead Reservation

FLATHEAD SERVICE UNIT


CANADA
GLACIER PARK
LINCOLN COUNTY
Olney
Whitefish
Columbia Falls
Coram
Apgar
40
2
93
Kalispell
PONDERA COUNTY
Big Fork
FLATHEAD COUNTY
35
104
SANDERS COUNTY
Thompson Falls
28
Hot Springs
FLATHEAD INDIAN RESERVATION
Polson
LAKE COUNTY
TETON COUNTY
93
Ronan
29
Plains
St. Ignatius
Dixon
POWELL COUNTY
10A 93
Frenchtown
Alberton
20
Missoula
10 12
MISSOULA COUNTY
GRANITE COUNTY
LEGEND
Service Unit Boundary
County Lines
Reservation
Paved Highways
Gravel Roads
PHS Indian Health Center
B.I.A. Agency
Contract Hospital

TRIBAL COUNCIL OF THE CONFEDERATED
SALISH & KOOTENAI TRIBES
DIXON, MONTANA

REV. 2/73 JR

1. GEOGRAPHY:

The Flathead Reservation was established by the Treaty of 1855 at the Treaty Ground of Hellgate, in the Bitterroot Valley, for the Flathead Nation, consisting of the Confederated Salish and Kootenai Tribes, Upper Pend d' Orielle, and friendly tribes of Washington who wished to consolidate under the designation of the Flathead Nation.

The Reservation includes parts of four counties--Flathead, Lake, Missoula, and Sanders in northwestern Montana. Flathead Lake forms the greater share of the northern boundary while mountains surround it on the other sides: the Cabinet and Coeur d' Alene Mountains, elevations 5,000-6,000 feet, on the west and the Mission Range, elevations up to 10,000 feet, on the east. These two ranges angle toward each other to form the southern boundary. The total tribally-owned area within these confines is approximately 620,000 acres.

The western part of the Reservation is generally rolling prairie land covered with grass and brush, which is used mostly for grazing land. The eastern half, however, is mostly agricultural and forested land situated in the mountainous Flathead River Valley and the foothills on the Cabinet Range. Flathead Lake, 189 square miles in area, is the largest and most prominent topographical feature of the area. Numerous lakes, reservoirs, creeks, three main rivers (Flathead, Little Bitterroot, and Jocko Rivers), and two National Game Refuges (the National Bison Range and the Ninepipe Reservoir Wildlife Refuge) are to be found within the Reservation.

The Reservation is characterized by a rather wide range of temperatures, with sudden shifts between high and low readings during the winter months. At Polson, on the southern shore of Flathead Lake, the January average temperature is 24° F. and the July average is 69° F. St. Ignatius and Arlee, located in the southern portion of the Reservation, report similar January and July averages, but the minimum recorded is -36° F. Rainfall is light, averaging 14 inches in the northern part of the Reservation and 15 inches in the southern end of the Reservation. The heaviest rainfall occurs during May and June, when from 3.5 to 6 inches fall; July and August are relatively dry. Killing frost occurs as late as mid-June and as early as September. The average growing season is between 129 and 180 days. The frost penetration ranges from 3.5 feet in the southern part of the Reservation to 4.5 feet in the northern part, depending on soil type.

The following are the principle reservation communities:

Arlee, was named after Chief Arlee (Second Chief of the Flathead Tribe), who, with his followers, moved to the new reservation in 1874. The Government recognized him as head chief of the tribe and took good care of his people's needs. Arlee is a community in the southeastern section of the reservation. It is located 15 miles from St. Ignatius and its 160 Indian families gain a livelihood from ranching and working in lumber mills.

Camas Prairie, located in the southwestern section of the reservation, was named by the U. S. Government for the root of the Camas plant which the Indians used medicinally. It is a rural area, approximately 30 miles from St. Ignatius, which is home to nine Indian families on widely dispersed ranches.

Charlo, located in the south central section of the reservation, was named in honor of Charlo (who lead the remaining Flatheads from the Bitterroot Valley onto the reservation in 1891), son of Victor, head chief of the Flatheads. Only three Indian families are living in this community which is 15 miles from St. Ignatius.

Dayton, located five miles north of Elmo is another, but much smaller, Kootenai village. Only six Indian families live here and make a living much the same as the people in Elmo.

Dixon, located in the south central section of the reservation, encompasses the area between Ravalli and Perma and the Moiese Valley to the north and is 12 miles from St. Ignatius. It became the site for the Flathead Indian Agency in 1910 because it was thought to be nearer the center of population. Since the Bureau of Indian Affairs vacated its offices in 1967 and moved its operations to Ronan, Dixon has become the seat of tribal government. Fourteen families live at the old agency compound and 35 families live in the surrounding area on small ranches and farms.

Elmo, located along the west shore of Flathead Lake in the north central section of the reservation, is the principle settlement of the Kootenai Indians residing in Montana. The community is 42 miles northwest of St. Ignatius and the 42 Indian families gain a livelihood from lumbering, berry picking, and harvesting Christmas trees.

Evaro, is a non-Indian community located just off the reservation near its southern boundary. Eight Indian families live near the community which is 25 miles from St. Ignatius. Industry is confined to logging, guest ranching and highway maintenance, but employment in Missoula is within easy commuting distance.

Hot Springs community (pop. 1,907) and town (pop. 664), located on the western edge of the reservation, is named for the thermal mineral springs in the area. Of the 64 Indian families living in the community, 54 of them live in the towns of Hot Springs and nearby Camas Hot Springs. The chief sources of employment are ranching, lumbering, harvesting Christmas trees, and working in the tribally-owned bathhouse. Hot Springs is approximately 46 miles from St. Ignatius.

Lonepine - Niarada, located approximately 65 miles from St. Ignatius in the northwestern section of the reservation, is a rural area in which seven Indian families live.

Pablo, located in the northeastern section of the reservation 19 miles north of St. Ignatius, was named in honor of Michel Pablo, one time interpreter at the old Jocko Agency and cattle king of the lower Flathead Valley. Twenty-three Indian families live in and around Pablo.

Polson (pop. 2,464) county seat of Lake County, is situated on the south end of Flathead Lake in the northeastern section of the reservation and was named in honor of David Polson, prominent area rancher. It is the largest community on the reservation, as well as the center of industry, tourism, services, and trading for a large area. Polson is 26 miles from St. Ignatius, and 184 Indian families (103-town, 81-rural) live in the vicinity.

Ravalli, named in honor of Father Anthony Ravalli (who rebuilt St. Mary's Mission, the oldest existing church in Montana), is located at the intersection of Montana Highway 200 and U. S. Highway 93 in the south central section of the reservation, five miles from St. Ignatius. It is largely a tourist stop, with several service stations, cafes, and an Indian Arts/Crafts Shop. Only five Indian families live here.

Ronan, located in the northeastern section of the reservation in the center of the Mission Valley, was named in honor of Major Peter Ronan, Indian Agent in 1877. The town of Ronan (pop. 1,347) is the trading, service, and medical center for the surrounding community (pop. 3,575). Fifty-eight Indian families live in the town and 95 live in the surrounding area. The chief sources of employment are lumbering, harvesting, Christmas trees, and ranching. Ronan is 12 miles north of St. Ignatius.

Round Butte, located in the center of the reservation, approximately 22 miles from St. Ignatius, is the home of ten families who gain a livelihood by ranching, lumbering, etc.

St. Ignatius (pop. 925), located in the southeastern part of the reservation, is part of the ancestral home of the Kalispel, Kootenai and Upper Pend d' Oreille Tribes. These Tribes, under the leadership

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
FLATHEAD SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			FLATHEAD **			LAKE **			MISSOULA**			SANDERS **		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	439	233	206	36	21	15	270	142	128	94	50	44	39	20	19
5-14	1060	515	545	113	58	55	659	317	342	161	79	82	127	61	66
15-24	829	445	384	59	27	32	524	293	231	168	86	82	78	39	39
25-34	466	239	227	46	21	25	249	139	110	121	58	63	50	21	29
35-44	334	154	180	34	11	23	185	95	90	81	33	48	34	15	19
45-54	272	139	133	32	18	14	173	88	85	33	14	19	34	19	15
55-64	191	95	96	13	3	10	133	71	62	19	8	11	26	13	13
65+	217	111	106	16	10	6	153	76	77	27	12	15	21	13	8
TOTAL	3808	1931	1877	349	169	180	2346	1221	1125	704	340	364	409	201	208

* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

** These are counties

of Chiefs Alexander and Michelle helped to select the site for, and construct, the Mission Church, namesake of the community, in 1854. By Easter of 1855, there were 1,000 of them living in the vicinity of the Mission. A decade after the founding of the Mission, their children were going to a school taught by Ursuline Nuns, and in 1875, the Bible was printed in their own language. Today, many of the community's 540 residents work in lumber mills, on ranches, and in public and government offices. Because the Health Center is located here, it will be considered the parent community in this document and distances from other communities will be related to it.

Larger cities in the area include Kalispell (population 10,526), 70 miles to the north, Missoula (population 29,497), 46 miles to the south, Great Falls (population 60,091) approximately 200 miles to the east, Helena (population 22,730) 149 miles to the southeast, and Butte (population 23,368), 140 miles to the southeast.

2. POPULATION:

The Population Table (see p. 97) indicates that less than half (39.4 percent) of the population is less than 15 years of age. Only a small (5.7 percent) percentage of the population reaches old age (65 years and older). This leaves 54.9 percent of the population in the ages 15-65, the labor productive years. Thus for every 1.2 persons in the labor productive years, there are 1.0 persons who are not. Actually, when correction is made for the school population, the handicapped, and the infirmed, the dependency ratio is probably nearer 1:1. The national dependency ratio is approximately 1:.8. The population is nearly equal as far as sex (males 50.7 percent, females 49.3 percent) is concerned.

3. TOTAL UTILITIES ON THE RESERVATION:

Electrical power is distributed by the Flathead Indian Irrigation Service. The hydroelectric site is owned by the Confederated Salish and Kootenai Tribes which is under lease by Montana Power.

The most popular commercial fuel is oil. There is no natural gas available in Lake County. The fuel is distributed by local dealers. There is also manufactured bottled gas available from local dealers.

4. COMMUNICATIONS:

The entire reservation is served by private telephone companies. The towns of Polson, Hot Springs, Ronan and St. Ignatius, have their own newspapers. The major newspapers serving the area are from Missoula, Spokane, and Great Falls. A television station is located at Missoula and radio stations are located at Kalispell and Missoula.

a. Social Services Involvement

The Social Services Branch provides active parallel and collaborative services to the Indian population to round out a full program in Community Mental Health. The Social Worker, Joseph Davenport, has been at St. Ignatius for several years and has defined his role quite succintly, so that there is relatively little competitive overlap between his activities and those of the Mental Health Staff. In general the Social Worker provides referral and advocacy services and chairs a community wide Mental Health Group which meets regularly.

These activities are described in the Service Unit Profile as follows:

> Social Services: The Social Services Branch is responsible for: (1) Medical casework (e.g., helping the patient to adjust to illness or accident, especially when this necessitates a change in life-style; solving family problems); (2) planning for medical care (e.g., making arrangements for psychiatric care, chronic care, transfer to another facility, and so on); (3) Environmental Health (e.g., making arrangements for financial help or homemakers services) and (4) Facilitating medical care (e.g., arranging for transportation to the hospital, clinic or other social, health and welfare agencies; arranging for foster or temporary care of children.
>
> The Social Worker assists in analyzing community needs and developing programs and services to meet identified needs. Areas of involvement have included the Halfway House for Alcoholics, Detox and Crisis Center, Lake County Advisory Committee on Mental Health, Lake County Mental Health Group, St. Ignatius Youth Recreation Committee, Northwest Regional Interagency Council on Services and Facilities for the Developmentally Disabled, and the Mission Valley Receiving Center (for dependent children).
>
> The Social Worker maintains resource files on public and private organizations and services, including those on the local, county, state, and national levels. This is used in securing services for beneficiaries and interpretation of services to the people. This material is also utilized in preparing a Directory of Resources which is distributed to persons in helping positions throughout the Reservation. The Social Worker also publishes articles on resources and the social work program in the IHS Newsletter and the Tribal newspaper. The Social Worker maintains library books, journals, pamphlets, etc., which are available to persons in helping positions.

The Social Worker plans and coordinates the meetings and activities of the Lake County Mental Health Group. He selects and supervises Social Work Trainees and supervises students in field practice from the University of Montana's Department of Social Welfare.

b. Flathead Mental Health Program:

On the Flathead Reservation James Newman, M.D., was assigned beginning in 1972. He has made excellent use of local community programs and provides clinical and program consultation to the many small towns and tribal programs up and down the length of this 120 mile reservation. One of the notable programs has been the integration of the tribal alcoholism program with the resources of a local private hospital which was discussed earlier as an Area model.

The local Community Mental Health Center provides a full time psychologist who also meets regularly with Dr. Newman. The exchanges of expertise result in full scale psychological services being made available to the Indian population. The psychologist has also been involved in tribal employment and alcoholism programs, and his judgment is much respected by the Flathead tribe. His long term experience with the communities and with Montana's resources make him an invaluable ally of IHS programs and staff.

Dr. Newman's quarterly report for the period October through November of 1972 provides a more concrete picture of his activities during the first year of his assignment to the Flathead Reservation.

1. Ongoing Activities
   (a). Continued direct patient contact with outpatients and inpatients. While most patients still referred from primary care giving people, a few were self referred. Also more people with acute and less incapacitating problems were seen.

(b). Continued consultation with primary care giving people. This includes evaluation for determination of PHS payment for psychotropic medications prescribed by contract physicians.

(c). Continued consultation to detox crisis center. This consisted of discussion with hospital physicians, detox counselors, alcohol counselors and the halfway house manager of inpatient management, follow up plans, procedural matters and informal training about alcoholism and crisis.

(d). More formalized training for detox counselors, alcohol counselors, the halfway house manager and other care giving people such as CHR's, CAP workers and welfare workers. The weekly sessions have dealt with the subjects of suicide, crisis and drugs and have utilized the techniques of lecture, discussion, role playing, film and outside speakers.

(e). Participant in community wide mental health group for the discussion of general issues relating to mental health.

(f). Member of Lake County Mental Health Advisory Board.

(g). Consultant to the Board that is responsible for the operation of the total alcohol program.

2. Actively engaged in planning:

(a). Education for contract physicians about the indications and appropriate use of psychoactive medications. A seminar, as previously considered, is still a possibility.

(b). Previously mentioned plans for consultation to a youth group interested in drug education has evolved to the point of obtaining interest among some adults in the need for "helpers" to involve themselves with teenagers and young adults in some type of preventive program. The next step will be contacting teenagers and young adults to get an idea of their needs and interests and to determine if they would be interested in working with us.

(c). In regards to previously mentioned planning for consultation to day care centers and head start programs, no ongoing activity or plans for further exploration have developed. It was decided that I would not be involved in such consultation because the staff of the Lake County Community Mental Health Center will continue in this capacity.

By April of 1973 these activities were expanded as indicated both under ongoing activities and in the details provided under other headings of the quarterly report covering January through March.

1. Ongoing Activities:
    a. Direct patient contact with outpatients and inpatients;
    b. Consultation to primary care giving people. This includes evaluations for determining PHS payment for psychotropic medications.
    c. Consultation to the DeTox Crisis Center and to the other components of the alcohol program (including the Alcohol Board). A medical screening procedure for patients and staff was established for the DeTox Ward. Also, help was given in the preparation of an article for **"Health Services World."**
    d. Participant in the Community Mental Health group for the discussion of general issues relating to mental health.
    e. Member of the Lake County Community Mental Health Advisory Board.

2. Other Activities:

    a. Training course on crisis. suicide and drugs for the alcohol program personnel and others was completed.
    b. Community Education: (1) Articles about alcohol and drugs were written for the tribal newspaper. (2) Speaking engagements at various community groups were arranged and carried out. The community groups and the subjects of discussion were as follows: Charlo PTA - The Alcohol Program; Pablo PTA - The Effects on School of Children's Home Problems; St. Ignatius Elementary School Teachers - One Parent Families; St. Ignatius Womens Club - Adult Family Life; Lake County Retarded Children's Association - situations that produce stress for retarded and slow children.
    c. Attendence at the conference on Human Sexuality in Billings.
    d. Approval from the Health Committee of the Tribal Council to train Mental Health Aids at Flathead was obtained.

3. Activity engaged in planning:

    a. Education for contract physicians about psychotropic medications: Several articles and a book (Klein and Davis) were circulated. The Polson doctors agreed to the idea of having a seminar. Arrangements will be made for this in the near future.

b. Development of a preventive program for youth and young adults: Further discussion with adult community helpers has led to the following: (1) The need for a preventive program for "problem free" children, teens and young people was again agreed upon. The helpers felt that they needed more knowledge and experience about community reactions to drugs and young people before they could develop a program. Therefore several helpers have applied for a grant to attend a two week training course that will include community approaches for the establishment of preventive programs. (2) The need for a community based program to deal with children and families who are having problems or who are seen as on the road to developing problems was also agreed upon. A group was formed to investigate the possibility of establishing a Tribally run Youth Home that would involve parents.

4. Ideas for exploration in the near future:

   a. Further training for the alcohol program personnel and others. This may include an attempt to more clearly define the helper's work role and what training would be appropriate for that role.
   b. Further consultation to the CHR's and other helping groups will be investigated.
   c. Evaluation of the alcohol program with Mrs. Dohner, and alcohol program staff.

c. Comments

Through the tribally operated New Careers Program a Mental Health worker has been selected (1973) and is being given supervised training. Mr. Little Gillan is based at St. Ignatius, the focal location of the IHS Health Center on the reservation. He is active in tribal affairs and is well known in the Indian community as a fellow tribesman and associate. Other tribal and nontribal paraprofessionals who are counselors in the Alcoholism program have regular meetings with Dr. Newman even though they are not IHS employees.

The real difficulties of this program lie in the problems inherent in the reservation itself. Much of the reservation was opened up to white homesteading in the 1930's or before, and the choice agricultural land along the rivers and highways is no longer Indian owned. Indian communities and allotments tend to be at the far edges of the fertile valley and in the foothills of its mountains. As a result, the non-Indian community has recently suffered a shocking jolt as the Flathead tribe began to asses its rights to charge for the use of gravels taken from Indian lands for road and farm development, for the use of fishing and marina facilities on their reservation lake of 189 surface acres, and for hunting and fishing permits. Even more daring, but having an impact on both logging companies and federal bureaus, is the tribal assertion of the legal necessity of enforcing conservation measures when logging contracts are let.

Much tension between the two populations is noted by a casual observer. The John Birch Society is strong among the white community, and most farm trucks carry plainly visible weapons. Non-Indian friends of the psychiatrist are known to refuse to come to a social gathering or dinner where Indian people may be present. The Flathead tribe does not have a history of agressive self assertion, and its members express mixed opinions when white tempers flare. So far what might be an explosive confrontation is periodically avoided.

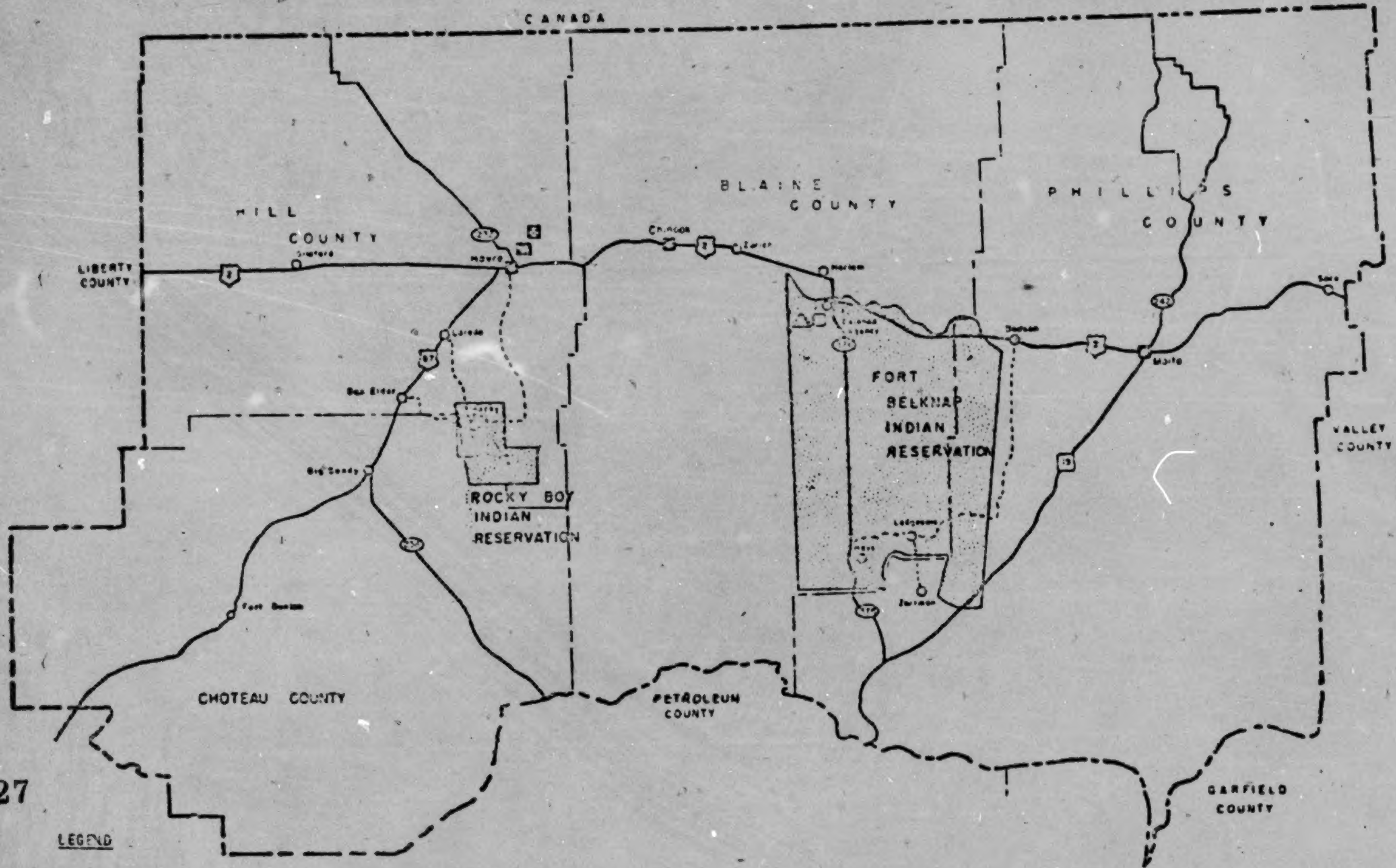
One factor which undoubtedly helps prevent collisions of interest from escalating has been a massive educational campaign in local tribal pride fostered through a monthly publication, CHAR-KOOSTA, the newspaper of the Salish, Pend O'reilles, and Kottenai tribes of the Flathead Reservation. Attractively printed twice monthly by photo offset, this paper develops unity among the confederated tribes by recognizing their common roots and their unique contribution. It includes as an insert the complete minutes of all tribal council meetings and features stories on tribal accomplishments and activities such as baseball games, bitterroot feasts, powwows, and church-related or program activities and employment. It also makes a real effort to present both sides of controversial issues, such as the logging operations on the Mission Mountains, the Constitution Revision Committee's activities, school board elections, and community meetings. CHAR-KOOSTA is sent free to all members of the tribe and by subscription to non-residents and non-Indians. Because it features photographs and Indian art work, it can be attractive to many in the community and should build a wide general circulation as well as being an organization for tribal expression and community pride.

A recent issue of CHAR-KOOSTA points out that the tribe as a whole has taken a stand of not allowing public meetings to escalate into controversy but nevertheless to answer firmly any expression of wrongs which they feel. If this does not solve a problem, the tribe is resolved to seek redress through the courts of the state and country. This seems to be a healthy way to keep tempers from flaring, but it is difficult for the local non-Indian to swallow since they are used to more rough and ready ways of settling disputes.

Dr. Newman has been busy and effective while engaged full time in the development of programs, and has developed a solid clinical and consulting base on this one reservation. With the coming of Fred Muhs to Blackfeet Reservation more communication between that program and Flathead programs has developed quickly. However, the isolation of the Flathead Reservation from the network of Highline reservations or the other programs to the south and east has been marked during Dr. Newman's tenure. This lack of IHS professional interchange and the marginality of being a non-Indian, and yet not a part of the white community ethos builds considerable stress of a personal nature into the family situation for any person in this post. While this has been offset to a certain degree by the Community Mental Health Center Consultant at the professional level, the social isolation is a factor that needs to be considered in replacing Dr. Newman when his tour of duty ends in 1974.

The development of Mental Health Programs on Flathead Reservation, utilizing local contracts and involving both Indian and non-Indian care-takers and clientele is doubly impressive as one becomes aware of the tensions between the two populations in many other areas of community activity. IHS Mental Health Program success has probably been possible because it has engaged concerned persons in programs designed to solve mutual problems, without a great deal of fanfare and publicity. In addition, there has been a solid base of clinical expertise appropriately available, complementing local resources in a non-competitive fashion. As Dr. Newman completes his tour of duty, it can be hoped that his replacement will have the same total community orientation and also bring or attract the clinical and teaching skills required to translate good ideas into functional realities.

3. Rocky Boy's Reservation


CANADA
HILL COUNTY
LIBERTY COUNTY
BLAINE COUNTY
PHILLIPS COUNTY
VALLEY COUNTY
CHOTEAU COUNTY
PETROLEUM COUNTY
GARFIELD COUNTY
ROCKY BOY INDIAN RESERVATION
FORT BELKNAP INDIAN RESERVATION
Gildford
Havre
Chinook
Zurich
Harlem
Laredo
Box Elder
Big Sandy
Fort Benton
Dodson
Malta
Saco
Lodgepole
Hays
Zortman
2
87
191
242

LEGEND

—— SERVICE UNIT BOUNDARY
– – – COUNTY LINES
▨ RESERVATION
—— PAVED HIGHWAY
- - - - GRAVEL ROADS

☐ PHS INDIAN HOSPITAL
■ CONTRACT HOSPITAL
★ PHS INDIAN HEALTH CENTER
○ PHS INDIAN HEALTH STATION
☒ PHS INDIAN HEALTH FIELD OFFICE

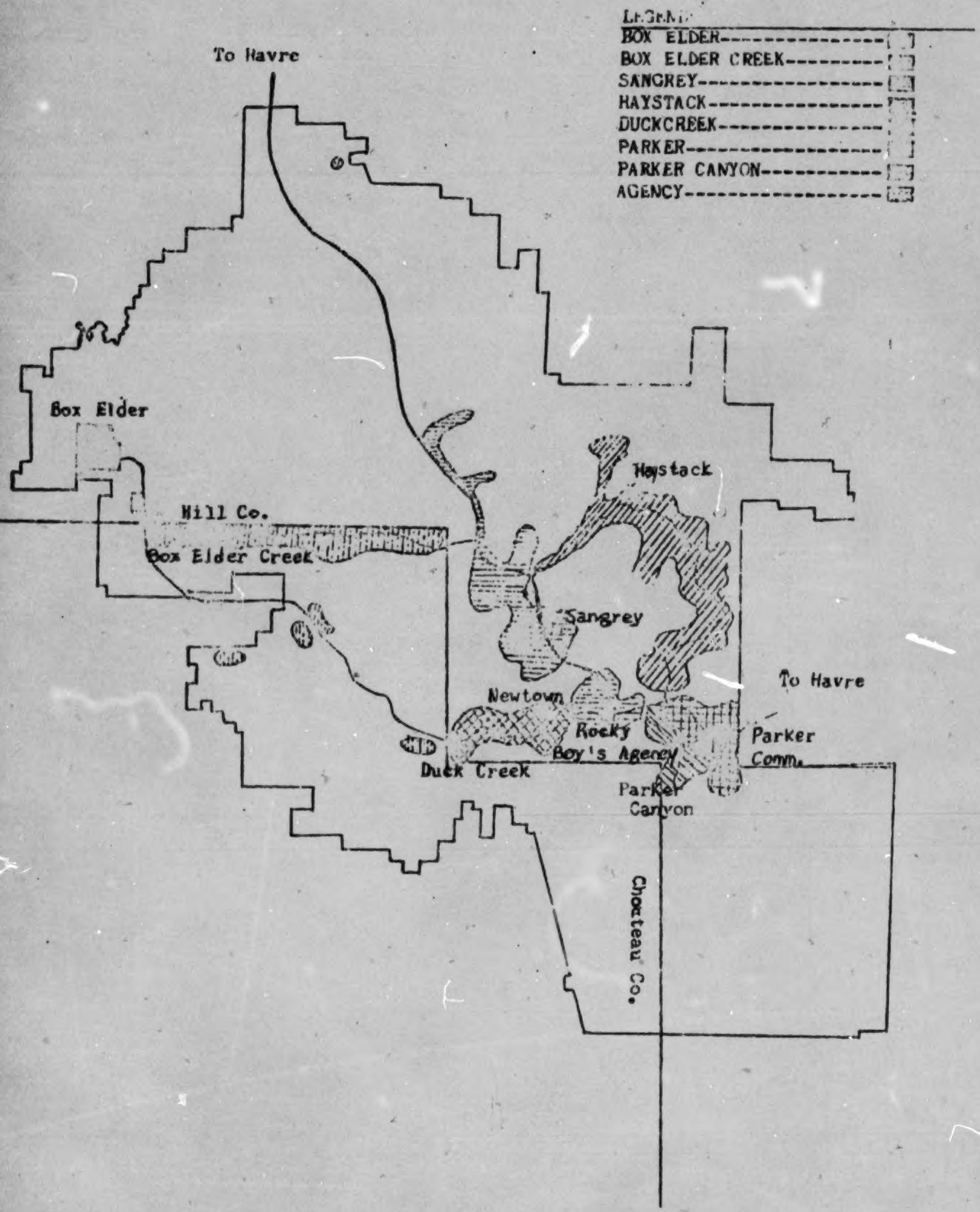
△ BIA AGENCY

Chippewa Cree Business Committee
Box Elder, Montana

REV. 2/73 JR

FORT BELKNAP–
ROCKY BOY
SERVICE UNIT

ROCKY BOY'S COMMUNITIES


LEGEND
BOX ELDER
BOX ELDER CREEK
SANGREY
HAYSTACK
DUCKCREEK
PARKER
PARKER CANYON
AGENCY
To Havre
Box Elder
Hill Co.
Box Elder Creek
Haystack
Sangrey
Newtown
Rocky Boy's Agency
Duck Creek
Parker Canyon
To Havre
Parker Comm.
Chouteau Co.

1. GEOGRAPHY:

The Rocky Boy's Reservation encompasses 107,613 acres in Hill and Choteau Counties of North Central Montana and is occupied by members of the Chippewa and Cree Indian Tribes.

The reservation, part of the old Fort Assiniboine Military Reserve, is the smallest in Montana and was established by executive order in 1916. Chiefs Rocky Boy (Chippewa) and Little Bear (Cree) were instrumental in getting the reservation set aside for their people.

Although the bulk of the reservation is situated in the Bear Paw Mountains, there are also areas of rolling foothills and flat farm land.

The springs and summers at Rocky Boy's are fairly mild with an average rainfall of about 8 inches, and a temperature that is rarely greater than 100. The winters are fairly mild with frequent chinook winds; however, occasionally the temperature does drop to 40 below.

Rocky Boy's Agency (pop. 189), located fourteen miles southeast of Box Elder (between Havre and Great Falls on U.S. Highway No. 87), is the tribal seat of government on the reservation. The Tribal Building, the Bureau of Indian Affairs' Office, Public Health Service Indian Health Center, elementary school, service station, tribal game farm, Community Action Program Office, maintenance shop, and two churches are located here. Approximately 100 Indian people live in the village. For the purposes of this document, the Agency will be considered the focal community and all distances will be relative to it.

Box Elder Creek Community (Ind. pop. 95), named after the creek which flows through it, is located approximately seven miles northwest of the Agency. Boneau Dam is the prominent topographical feature of the community, as well as a good spot for trout fishing. Although the creek bottom is fairly wide in most places, very little of it is cleared and agriculture is currently limited to gardening and hay production on a small scale. Future plans call for clearing more of the creek bottom so that it may be used for a Christmas tree enterprise and/or the raising of forage crops. At present, most of the community's residents are wage earners.

Duck Creek Community (Ind. pop. 85), begins on the western outskirts of the Agency and is situated along several miles of the creek for which it is named. It is the gateway to the Sandy Creek Recreational Area which is excellent for camping and fishing. Aside from the privately-owned service station at New Town, residents gain a livelihood from ranching and a limited amount of farming. New Town is a cluster of ten homes within the community which has a common water system.

Haystack Community (Ind. pop. 291), situated around the prominent Haystack Butte (elevation 4,768 ft.), is the second largest community on the reservation. It begins about two miles east of the Agency and extends northward for several miles. Most of the community is situated in the grassy foothills of the mountains in the northeastern portion of the reservation. Its residents are ranchers and/or wage earners at the Agency.

Parker Community (Ind. pop. 137), named after a day school of the Bureau of Indian Affairs days, is located in a wide mountain canyon two miles east of the Agency. Beaver dams along this fork of Box Elder Creek provide good fishing. Most of the community's livelihood comes from wages.

Parker Canyon Community (Ind. pop. 78), is located about one and one-half miles southeast of the Agency. Sandy Creek flows down from Centennial Mountain, prominent topographical feature of the community, and through this picturesque canyon. The many beaver dams obstructing the creek's course are excellent places to fish for trout. The few people that live here are mostly engaged in ranching.

Sangrey Community (Ind. pop. 216), largest community on the reservation, is located three miles north of the Agency. Its namesake Sangrey Day School of Bureau of Indian Affairs days, still stands. Sangrey is a native religious center of sorts, for the ceremonial grounds are here. About one-third of the residents gain a livelihood from ranching, and the rest are wage earners.

Box Elder, (pop. 479), located fourteen miles west of the Agency, is the closest settlement. It consists of a general store, two saloons, a service station, post office, cafe, and high school. Approximately 149 Indian people live here. The closest major trading center is Havre (pop. 10,558), 30 miles to the north, and the closest metropolitan area is Great Falls (pop. 60,091), 100 miles to the south.

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
ROCKY BOY'S SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			CHOTEAU			HILL		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	272	139	133	18	11	7	254	128	126
5-14	590	299	291	62	28	34	528	271	257
15-24	336	155	181	18	10	8	318	145	173
25-34	181	81	100	21	12	9	160	69	91
35-44	157	69	88	15	4	11	142	65	77
45-54	107	51	56	10	6	4	97	45	52
55-64	74	43	31	5	5	-	69	38	31
65+	73	41	32	7	5	2	66	36	30
TOTAL	1790	878	912	156	81	75	1634	797	837

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* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

2. POPULATION:

From the description of the reservation communities, it is evident that 90 per cent of the population lives in the east-central portion of the reservation, which is the most mountainous part. The official tribal enrollment is 1,790. The Home and Premise Survey (HSM-41) completed in 1972 lists 1,086 persons living on the reservation. The census recommended by Indian Health Service Headquarters is 1,790. Community descriptions are based on the HSM-41 survey.

As a whole, 68% of the reservation population are in the age group under one-year through age 24, 48% of the population are 14 years or under, and 33% of the population are between the ages of 5 and 14. Males constitute 49% of the population and females 51%. See the following chart for a more complete breakdown:

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
ROCKY BOY'S SERVICE UNIT
FISCAL YEAR 1973

Per cent of Overall Population		Total	Male	Female
15%	Under 5	272	139	133
33%	5-14	590	299	291
20%	15-24	366	155	181
10%	25-34	181	81	100
8%	35-44	157	69	88
6%	45-54	107	51	56
4%	55-64	74	43	31
4%	65+	73	41	32
	TOTAL	1,790	878	912
			49%	51%

* Population is based on the 1970 Census and projected by Headquarters in memo dated November 23, 1971. (See page **112 for population break-down** by age, sex and county.)

a. Mental Health Services

Mental Health Services are described in the 1973 Service Unit Profile as follows:

> Mental Health is a new program on the reservation. Currently two positions are assigned to Rocky Boy's, a mental health professional and an aide. The Mental Health Branch is involved in therapy to individuals on the reservation, consultation to the Box Elder School, consultation to the Alcoholic Program in Havre and is directly involved in community organization problems on the reservation, recently developing a day care center and currently studying the feasibility of establishing a nursing home at Rocky Boy.

This brief description is fleshed out in quarterly reports prepared by by Robert Morash, MSW, while living on and serving Fort Belknap. He also has attempted to provide consultation to Rocky Boy's Reservation. Some of needs and accomplishments of this program are clarified below. The omissions indicated refer to activities relevant only to Fort Belknap.

(Undated, probably July, August and September 1972)

Clinical

> Clinical activities during this quarter remain generally the same as in the past with the possible exception of the workload in the Havre area. This has increased somewhat at the expense of time allotted to the Rocky Boy Service Unit. While I have discussed this with Dr. Rockey and he has indicated that he would like to have me spend more time at Rocky Boy, he also recognizes the need for the use of the mental health consultant in the Havre area.

Community Development

> The major emphasis in terms of community development for this quarter has continued to be the Emergency Care Center and the Day Care Center. The current status of the Center is that all necessary documentation has been negotiated and the board of directors has been selected and has met. The job descriptions have been written and posted and applications are arriving. The building has been secured. It appears that the program will begin within three weeks of the writing of this report. Mrs. Turcotte will now be serving on the board for the Center. After one year she will be replaced by a local person.

QUARTERLY REPORT - December 1972
Fourth Quarter

Experiences

1. Training:

During this quarter the Mental Health Aide at Rocky Boy attended a health planning workshop in Great Falls. The workshop has application with respect to comprehensive mental health planning and the mental health aide has applied some of the principles learned at the workshop in her work with the Day Care Center. Mrs. Turcotte and I anticipated developing a training-visitation to Boulder and Warm Springs for her and the Aides at Poplar. It is hoped that we can formalize this in the next few weeks. Some of the material which we have thrown around includes some rudiments of genetics so that the girls involved will have some idea as to what the programs are at Boulder and some information as to different types of therapies such as behavior modification which is practiced at Warm Springs.

Clinical

Clinical activities in this quarter continued to be generally the same as in the past. One problem in this area is day to day fluctuations in appointments; I have no way to resolve the peaks and valleys at this time. The heaviest day during the quarter was thirteen patients and the lightest day was two patients.

Community Development

The major emphasis for the mental health program during the quarter was on the day care center at Rocky Boy which is open and functioning at this time and serving eight children. Program was designed for twenty and while acceptance of the program is beginning it will probably be months before the center is functioning to capacity.

2. New Problems

One of the problems which at this time appears to be irresolvable is the need for a meeting place for group activities on the Rocky Boy Reservation. While at present it appears that nothing can be done I feel that every avenue should be explored to lease or purchase a facility for group activities.

An additional problem which is relatively new and applies primarily to off reservation Indians is the lack of transportation to health care delivery systems. Many people appear to be not receiving mental and physical health care services because they are unable to seek the services at appropriate times.

b. Comments

It is always easier for remotely located Administrators to combine populations than it is for red people to travel fifty or more miles on secondary roads and to cross cultural and political barriers. The Chippewa and Cree located here have the shortest Reservation history of any tribe in Montana, and probably in the United States, since they were not in that status until 1916. As a group there are no deep antipathies noted in their relationships with the Gros Ventre and Assinboine on Fort Belknap. However, there are no obvious shared traditions that help motivate them to travel to develop joint programs or use facilities in one another's territories.

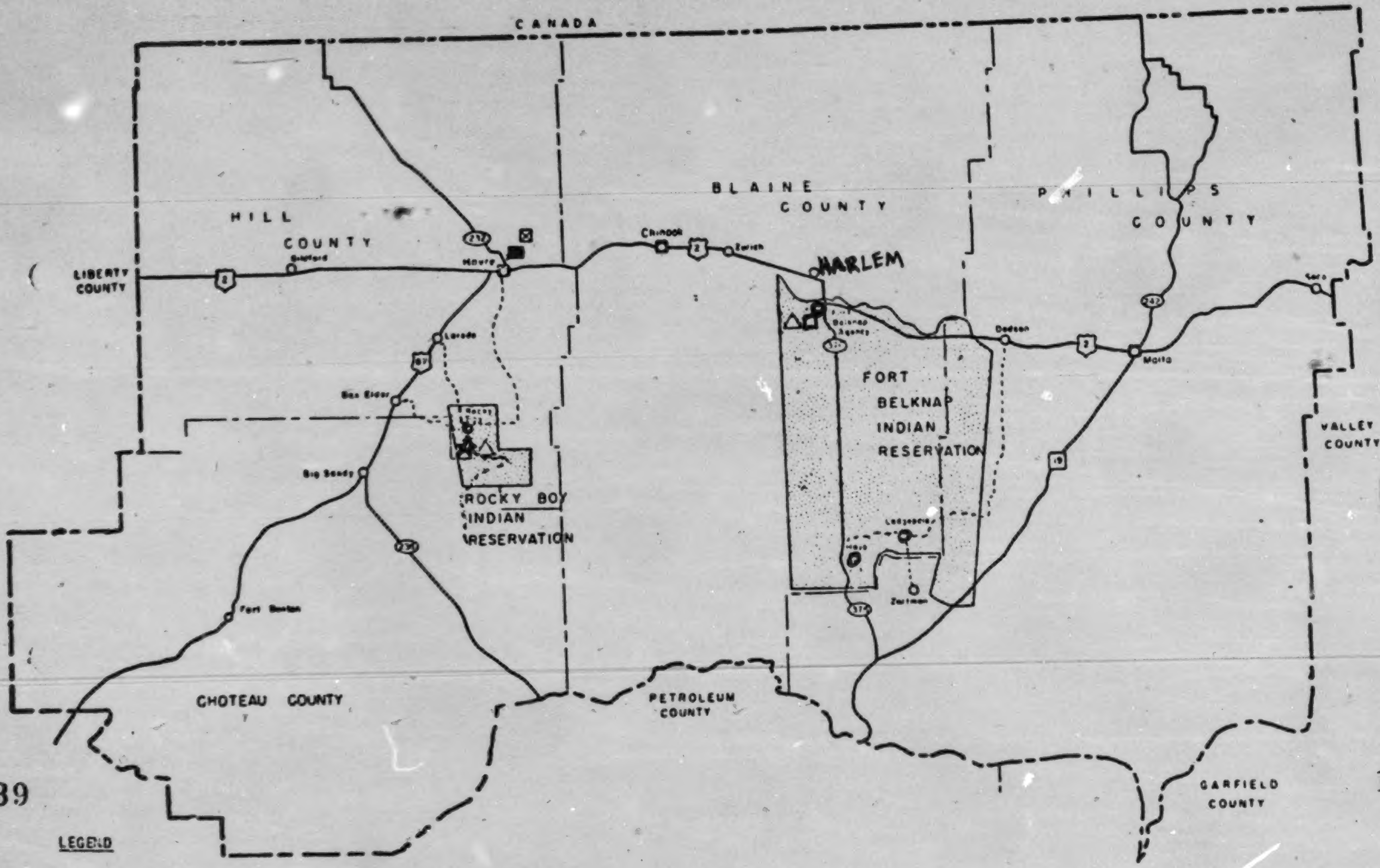
This distancing is obvious in the utilization of general medical services. The population at Rocky Boy's will make use of the IHS Health Center for outpatient care. However, if specialists or hospitalization is required, they prefer to go to Havre or other off Reservation Hospitals under contract care and third party payments. They do not make regular use of the IHS Hospital located on Fort Belknap which supposedly serves both Reservations.

Each Community and Tribe has a need to develop its own local services, particularly at a preventive level. How scarce professional services can be allocated and how to justify their deployment are difficult problems and insoluble in terms of most available models since epidemologic information in mental health is yet to be adequately developed.

It is not clear at the present time that there are any available local non IHS resources that could be developed as has been the pattern on the Crow and Northern Cheyenne Reservations to solve similar problems. Unfortunately, IHS and Tribal representatives did not feel that the development plans for a Northern Montana CMHC would meet their needs when this was under discussion in 1972-1973.(see Fort Belknap). This has aborted any attempts to utilize the Flathead model to develop a full range of services.

It would appear that the emerging solution is foreshadowed by the vigor of the Day Care and other local programs, developed through IHS negotiated contracts and IHS supported locally recruited Mental Health workers. However, clinical services back up at the professional level and continuing consultation at frequent and locally involved levels do seem to be needed, in addition to Area Office visitations. Whether sharing one or more IHS professional staff from Browning or Fort Belknap will solve these problems remains to be seen.

4. Ft. Belknap Reservation


CANADA
HILL COUNTY
BLAINE COUNTY
PHILLIPS COUNTY
LIBERTY COUNTY
VALLEY COUNTY
CHOTEAU COUNTY
PETROLEUM COUNTY
GARFIELD COUNTY
Gildford
Havre
232
2
87
Laredo
Box Elder
Rocky Boy
Big Sandy
ROCKY BOY INDIAN RESERVATION
Fort Benton
Chinook
Zurich
HARLEM
Fort Belknap Agency
FORT BELKNAP INDIAN RESERVATION
Dodson
Malta
242
19
Saco
Lodgepole
Hays
Zortman
376

LEGEND

- —— — SERVICE UNIT BOUNDARY
- — — — COUNTY LINES
- ▨ RESERVATION
- —— PAVED HIGHWAY
- - - - - GRAVEL ROADS
- □ PHS INDIAN HOSPITAL
- ■ CONTRACT HOSPITAL
- ☆ PHS INDIAN HEALTH CENTER
- ○ PHS INDIAN HEALTH STATION
- ☒ PHS INDIAN HEALTH FIELD OFFICE
- △ BIA AGENCY

FT. BELKNAP COMMUNITY COUNCIL
HARLEM, MONTANA

FORT BELKNAP—(ROCKY BOY) SERVICE UNIT

REV. 2/73 JR

1. GEOGRAPHY:

The Fort Belknap Reservation encompasses 1,200 square miles in Blaine and Phillips Counties of north central Montana and is occupied by members of the Gros Ventres and Assiniboine Indian Tribes. This service unit serves the entire Reservation as well as Indian people living in border towns such as Harlem, Dodson, Landusky, and Zortman. It also has administrative jurisdiction over the Rocky Boy's Health Center twenty miles southwest of Havre. See map on page **facing.**

The northern three-fourths of the reservation drains into the Milk River and consists of flat treeless glacial plains and alluvial bottom lands. The southern fourth of the reservation drains into the Missouri and consists of rolling grasslands, river "breaks" and mountain ranges (Bearpaw and Little Rocky) which reach an elevation of about 6,000 feet.

The climatic characteristics vary by season and year. The total amount of annual precipitation varies from 9 to 10 inches in the plains portion to 17 inches in the mountain portion. Temperatures can range from a minus 50° F in the winter to over 100° F during the summer months of July and early August. The low relative humidity tends to make sub-zero and high temperatures more tolerable. The frost-free growing season is from 119 to 131 days.

Harlem (population 1,094), located near the northwest corner of the reservation, is the closest trading center. More services are available in Chinook (population 1,813) and Havre (population 10,558) to the west or Malta (population 2,195) to the east. Great Falls (population 60,091), approximately 160 miles southwest of the reservation is the closest metropolitan area. Billings (population 61,581) is 206 miles south of the reservation.

Fort Belknap Agency, located 5 miles south of Harlem on U.S. Highway #2, is the seat of tribal government on the reservation. At the present time, it is largely a "government" community but as more tribal housing units are built in the area, its composition will change. At present, there are 125 Indian families living at the Agency. The Milk River Valley Community is also located in the northern sector of the reservation. It extends eastward from the Agency to the reservation boundary near Dodson, Montana, and is home for 38 Indian families.

Hays Community is located on the western side of the Little Rocky Mountains 35 miles from the Agency in the southern sector of the reservation. It is composed of a small non-Indian owned townsite of 43 Indian occupied homes surrounded by a rural area of about 58 Indian homes, all widely dispersed.

Lodgepole Community, situated about 10 miles east of Hays on the eastern side of the Little Rocky Mountains, is home for 69 Indian families.

Beaver Creek, a community of about 15 Indian families, is located 10 miles southeast of Lodgepole.

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
FORT BELKNAP RESERVATION
FISCAL YEAR 1973

	TOTAL			BLAINE			PHILLIPS		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	184	93	91	167	84	83	17	9	8
5-14	624	330	294	537	284	253	87	46	41
15-24	322	166	156	280	144	136	42	22	20
25-34	175	84	91	151	73	78	24	11	13
35-44	184	99	85	157	86	71	27	13	14
45-54	134	78	56	115	67	48	19	11	8
55-64	102	49	53	79	37	42	23	12	11
65+	127	65	62	104	55	49	23	10	13
TOTAL	1852	964	888	1590	830	760	262	134	128

* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

2. POPULATION:

From the description of the communities, it is evident that approximately three-fourths of the population lives in the southern sector of the reservation.

As a whole, 61 percent of the service unit population are in the age group under one year through age 24; 43.6 percent of the total population are 14 years of age or under. Only 17.4 percent of the total population are between the ages of 15 and 24. Thirty-nine percent of the population is over the age of 25 years. Males constitute 52 percent of the population and females 48 percent. See Population Table, page 120 **for a more complete breakdown.**

According to MRBI Report Number 198[1/] published in 1972, the trend of Indian births has decreased from 58 per 1,000 in 1963 to 29.1 per 1,000 in 1970. However, this is still almost twice the birth rate of the non-Indians adjacent to the reservation.

The report points out there has been a reduction in the Indian birth-death ratio from 6.8:1 in 1960 to 2.6:1 in 1970, but the ratio is twice that of the non-Indian population nearby.

The report utilized the age distribution pattern and its changes over time to find that the Indian population in the 25 to 34 bracket was much lower than the surrounding area; this is indicative of a population of high outmigration.

It was also found that the percentage of Indian population of elementary school ages (0-14 years) was much higher than the surrounding area.

In the 35-64 age group (the older working force), the Indian population is quite a bit lower than the surrounding county area.

From 1960 to 1970 the decline of the 0-14 aged population decreased 6.1 percent, compared to 4.2 percent for the surrounding area.

The Indian population will continue to have a high potential for natural increase because of the increase in the percentage of the Indian population in the 15 to 19 age group and the relatively high percentage of Indian population in the 0 to 14 age bracket. However, due to the decline in the 0 to 14 age group from 1960 to 1970, the future potential for increase will probably not be as great as in the past but the lower rate will not be realized until this age group passes beyond the child bearing age.

[1/] U.S. Department of Interior, Bureau of Indian Affairs, Missouri River Basin Investigations Project, The Fort Belknap Reservation Area, Its Resources and Development Potential, Report No. 198, pp. 13-18, 1972.

6. EDUCATION FACILITIES AND LEVEL:

Shown below are the schools located within the boundaries of the Fort Belknap Reservation and the 1972-1973 school census:

SCHOOL	LOCATION	GRADES	MILEAGE FROM HARLEM	INDIAN STUDENTS
Hays	Hays	HS-8	32	149
Lodge Pole	Lodge Pole	HS-8	44	103
St. Paul's Mission	Hays	1-12	34	86
Beaver Creek	Lodge Pole	6-8	52	3
Harlem Elementary	Harlem	HS-8		294*
Harlem High School	Harlem	9-12		102
College(s)	Montana, Washington, California			121
			TOTAL:	858

*Includes 8 special education students.

7. TOTAL RESERVATION HOUSING:

Recent Bureau of Indian Affairs figures show that of the total 397 housing units on the reservation, 265 or 67 percent, are in standard condition and 132 are in sub-standard condition. Of the 132 in the sub-standard condition, 88 percent, or 116 homes, were classified as needing replacing and only 16 needed remodeling.

Since 1970, the Tribal Housing Authority and the Bureau of Indian Affairs have made considerable progress in trying to overcome the unfavorable housing conditions. During Fiscal Year 1971, a total of 73 new homes were completed. Fifty of these homes are low rent houses constructed near the Fort Belknap Agency, 22 Mutual Help homes are located at the Agency and one home has been built with a credit loan. Also, 30 homes received housing improvement repairs. During 1972, 22 Mutual Help homes were completed in the Lodge Pole community. Another 60 Mutual Help homes will be constructed in the near future.

Although Mutual Help homes may contribute toward a better and newer home for residents, they do not always help relieve the problem of overcrowding which now exists for many Indian families.

8. NATURAL RESOURCES AND ECONOMY:

The Fort Belknap Reservation is basically rural and agricultural in nature. About 71 percent of the land within the reservation is held in trust status for the Indians. Of this amount, one-fourth is in tribal trust status and about three-fourths is in allotted trust status. A special problem which exists with most of the allotted land is multiple ownership. Over half of the allotted land is owned by two or more persons, which presents problems in wise use of the land, difficulty in administration, difficulties in leasing and/or selling the property. Most of the Indian-owned dryland is used for ranching purposes, but in the last ten years there has been an effort to create dryland wheat farms (5,000 acres in 1967). Whether these farms are economical depends greatly on the production which, in turn, is dependent on favorable weather conditions, prices received for crops, and national farm policies. Almost all of the irrigated land on the reservation, along the Milk River, is used for hay production.

Agriculture cannot support all the needs and wants of all the persons on the reservation even if all the potentials of production are utilized to their fullest extent.

The reservation does not lie in a good geographic location to enhance tourism. However, it has some recreational potentials which if promoted could attract more tourists. These are the major rivers, the Missouri and the Milk; the mountains, Bearpaws and Little Rockies; the wildlife refuges; Indian battlefield; old historical mission; gold mining towns, and camping/picnic grounds.

The recreation and tourism potential can benefit from tourists traveling through the reservation by having a complete and well managed service and shopping complex.

All natural lumber resources were destroyed by fire in 1936. Mineral production on the Fort Belknap Reservation has been limited primarily to taprock. There are deposits of limestone near the southern edge of the reservation and there are potentials for gold, silver, coal, bentonite, oil, and gas.

Most Indians, as in any other society, do not want charity but rather stable employment whereby they can have pride and self-esteem in their own ability to earn a living.

The Tribal Council is trying to lure industry to the reservation but this is not an easy task. It can offer an adequate labor force, land, tax advantages, federal contracts, property security. These are not enough to compensate for the limited availability of raw materials, marketing costs, and isolated location.

In 1970, the Fort Belknap Builders was established on the reservation. This firm developed an operation to build homes on a pre-cut compartmentalized semi-prefab basis. It was to have employed over 100 individuals but at the height of production was only able to employ 50 people on a 3-shift basis. The operation folded in 1972.

Currently, there is little industry on the reservation. There is a small bronze casting plant and Indian handicraft shop on the agency which is run by the Indian people and employs about a half dozen people. Attempts are being made to attract light industry to the reservation.

Employment opportunities on and near the reservation are primarily in agriculture and generally seasonal. A few jobs are available locally with the Indian Health Service, the Bureau of Indian Affairs, and in the small surrounding communities. Some of the jobs are permanent, others are seasonal.

The Community Action Program plays an active role on the reservation trying to get community involvement in community-wide projects for the improvement of reservation living conditions. CAP has an active Legal Services Program on the reservation to provide free legal services to indigent people. CAP is also involved in a health aide progtam that bears similarities to the Indian Health Service Community Health Representative Program and a nutrition education program intended to give the Indian people training in eating and preparing well-balanced diets.

The Bureau of Indian Affairs administers the majority of the Federal Programs for Indian people not directly related to health. Some of these programs have an indirect effect on health such as the welfare program, the education program, and the housing improvement program. The BIA also pays for custodial care in nursing homes for Indian patients.

11. SOCIAL-CULTURAL CHARACTERISTICS:

The Fort Belknap Indian Reservation is shared by members of the Gros Ventres (pronounced Gro Von) and Assiniboine Tribes.

The Assiniboine Tribe is a detachment from a fragment of the Yanktonai Sioux Tribe. Their early habitat was in the Rainy Lake and Lake of the Woods in northern Minnesota. In search of food, they moved westward in the late 1600's and early 1700's and settled in the Saskatchewan-Montana area. To facilitate hunting for food, the tribe broke into two bands. When the government granted rations to the Indians and established reservations, the band of Assiniboine that received rations at the Milk and Missouri Rivers were enrolled at the Fort Peck Reservation and the Assiniboine who received rations at the Fort Belknap Agency were enrolled at the Fort Belknap Reservation. There were approximately 8-10 thousand Assiniboine in 1836 but epidemics and wars reduced their numbers to 2,400 by 1880.

The Gros Ventre Tribe at Fort Belknap is a fragment of the Arapahoe Tribe. A treaty of October 17, 1855, granted hunting grounds for the Blackfeet, Crow, Blood, Piegan, Gros Ventres, and Assiniboine Tribes which was roughly the territory from the Yellowstone River north to the United States-Canadian border and from the Rocky Mountains in Western Montana to the junction of the Yellowstone and Missouri Rivers.

In 1868 one of the first trading posts was established near the present town of Dodson. Because of harrassment from warring Sioux, the fort was moved in 1869 to an area near the present town of Chinook, Montana. The new fort was called Fort Belknap, named after a Secretary of War under President Grant, and became the government agency for the Gros Ventres and Assiniboine Indians living in the area. An act of May 1, 1888, set aside the land for Fort Belknap, Blackfeet, and Fort Peck Reservations. Late in 1888, or early 1889, the Agency was moved from Chinook to its present site five miles east of Harlem on the northeast corner of the Fort Belknap Reservation. In 1921, the government allotted 539,065 acres to the 1,171 Indians enrolled on the reservation.

In 1935 the Indians of the Fort Belknap Reservation adopted a constitution and by-laws under the Indian Reorganization Act. They were chartered under the name of the Fort Belknap Indian Community of the Fort Belknap Reservation. The Council is comprised of 12 members, six from each tribe, with six members elected every second year by popular vote and each member serving a term of four years. The Tribal Council is the official governing body of the Tribe.

For many generations, members of both tribal groups have intermarried among themselves and with non-Indians so that today there are less than a hundred pure bloods in either tribe. English is the language of common use because of the intermarriage and because the two tribes are of different linguistic families.

While the average educational level of individuals on the reservation is approximately that of the eighth grade, the majority of the population is quite astute as far as good medical practice is concerned and are alert to what is happening at the hospital.

The big social events are the "Indian Days" gathering in late summer and the "Mid-Winter Fair" in February. The give-away is one of the festivities at the Indian Days celebration as well as at some of the 10 or 12 dances that are held during the year. The Sun Dance has not been celebrated for a long time nor do the Fort Belknap Indian people engage in the "stickgame".

12. DAY-TO-DAY PROGRAM SERVICES:

The Fort Belknap Service Unit provides direct medical and dental services and community health services to approximately 1,852 people living on the reservation and in the adjacent communities.

a. Hospital or Clinic Services:

The direct medical services include a 22-bed hospital, an outpatient clinic, emergency room and ambulance service, an outlying clinic at Hays, supportive laboratory services, and contract facilities.

The hospital provides medical, pediatric, obstetric, and some minor surgical services. The average daily patient load for Fiscal Year 1972 was 10.6. There were 66 newborn admissions in Fiscal Year 1972 with a newborn average daily patient load of 0.6.

The regular outpatient clinic operates Monday and Friday mornings for people brought to the hospital by the tribally operated bus. Monday, Wednesday, and Friday afternoons are open clinics. The General Clinic is open from 1:00 to 8:00 on Monday and Friday. In Fiscal Year 1972, there were 13,224 outpatient visits at the hospital. The emergency room at the hospital is open twenty-four hours per day, seven days per week, for emergencies.

a. Mental Health Programs

As indicated in the discussion of Rocky Boy's programs the same IHS Social Worker serves both Reservations. Robert Morash has his duty station listed officially at Box Elder, seventy-five miles away on the Rocky Boy's lands. However, he lived in Harlem, and since both Reservations were part of the same Service Unit, headquartered at Fort Belknap IHS Hospital, he has been active in developing Mental Health Programs at both locations.

As Mr. Morash was struggling to provide services and build programs on these two Reservations, there were other developments in the region outside of IHS. In 1971 an application for construction and staffing of a CMHC for Northern Montana. Two references in the Area Chief's reports reveal the efforts of IHS and the Tribes at Fort Belknap, Rocky Boy's and Browning to participate in planning this project.

The first describes conference and site visit activities in the Fall of 1971.

Meetings attended:

a. Annual Meeting of State Mental Health Authorities Region Eight, Rapid City, South Dakota, October 6-8,1971: Mrs. Dohner attended this meeting as a representative of Indian Health Service, Mental Health Branch. This is the first time the IHS has been invited to send a representative. NIMH is bringing more and more pressure to bear on community mental health centers regarding the coordination of mental health resources with their catchment areas and involvement of all segments of the population in decision making, program planning, and receipt of services. In Region Eight, the I Bian population is an important minority group which heretofore has received short shrift from community mental health centers. Some attention was focused on the problems of people on the reservation. Some useful discussion of ways to coordinate services of IHS and community mental health centers also occured.

b. Northern Montana Hospital Application for NIMH Construction Grant and Staffing Grant for Northern Montana Community Mental Health Center, October 18-21, 1971: The NIMH construction funds are to establish in-patient psychiatric services at Northern Montana Hospital. NIMH construction funds are never committed without a plan for comprehensive community services, so, at the same time there is an application for a staffing grant for the Northern Montana Comprehensive Community Mental Health Center. Mrs. Dohner accompanied the site visitors for two reasons:

1. IHS is also commiting construction funds to the new hospital.

2. A condition for the staffing grant is that the application must give evidence of planning with and services for Indian people. As a result of the site visit, vigorous plans are now underway to involve Indian people on the reservation in planning and to assess resources and gaps in services. The first meeting will be at Rocky Boy's, November 1, with Mr. Crandell of Northern Montana Mental Health Center. The NIMH site visitors made it quite clear that the grant would not be funded until there was evidence of in-depth planning with IHS and people on the reservation.

The second reference to this project is much more pessimistic. It is dated April 28, 1972, and is also excerpted from the Area Chief's monthly reports. On the occasion of this conference apparently Dr. Gustafson himself attended instead of Ms. Tower (Dohner).

> Meeting with Staff and Board of Directors of Northern Montana Mental Health Center: Mr. Theodore Fasso of the Regional Office, Dr. Blaine Wasescha, Mr. Robert Morasch, and I represented the Indian Health Service at this meeting to discuss working relationships between the Mental Health Center and the IHS. We found that the Northern Montana Mental Health Center was offering very little of value to the Indian reservations. The hospitalization that will be possible at Cut Bank and at Havre will only be for placement and regular medical beds scattered around the hospital. This essentially offers nothing beyond what we already have at Browning and at Havre. What instead we heard from the Northern Montana Mental Health Center were a lot of phrases like "cross fertilization" and "coordination." The only substantial agreement was for

> joint case conferences. We recommended to them that they place mental health professionals as near to full time as possible on the reservations, rather than part time people who will not be known well enough to be trusted or useful. Whether or not the Northern Montana Mental Health Center accepts our strong recommendation is to be seen.

With the collapse of these negotiations Fort Belknap continued to use Warm Springs State Hospital as a resource when any of its clientele needed hsopitalization for mental illness, and Mr. Morasch attempted to develop local programs.

A serious recurring problem in developing local staff on the Fort Belknap Reservation has been housing for either professional or paraprofessional staff. This theme constantly recurs in all of Mr. Morasch's reports, two of which are quoted below. Omissions refer to activities relevant only to Rocky Boy's Mental Health Programs.

> Quarterly Report-1972
> ?Aug., Sept., Oct.?
>
> Activities
>
> Activities and experiences:
> One of the mental health aides (Sybil Colliflower) has expressed a desire to resign as she anticipates completing her college education. Basically the reason for the resignation was her inability to secure quarters at the Fort Belknap Reservation. Up to the time of her leave of absence Mrs. Colliflower did a completely adequate and in most areas exceptional job at Fort Belknap Agency. I certainly would recommend that she be rehired following her graduation. Additional training activities with the other aide have included: attendance of the seminar given at the college of Great Falls by William Glasser, training activities oriented around Day Care Centers, training sessions around interviewing, dynamics and techniques of intervention in working with individual clients.
>
> Problems
>
> Recurrent:
> The recurrent problems listed in the last quarterly report continued to be evident. I am referring to the jurisdiction with respect to state institutions and individuals on the reservation. It is quite impossible at this time to hospitalize anyone for

their protection, involuntarily, if they reside on a reservation. Additionally there has been some difficulty with the county attorney who, in the opinion of Dr. Rockey and myself, has"dragged his feet" with respect to working with this kind of problem. The legal aide attorney has recently resigned and will begin taking over the job of county attorney and at that time things should get better with respect to dealing with problems in this area. Another problem continues in the lack of housing at the Fort Belknap Reservation; I feel it will be extremely difficult to recruit people for that job unless housing is made available. The one apartment which might become available in the old nurses' quarters, in my opinion, is not adequate for a person who has a family.

Needs

There continues to be a need to revise the basic data reporting form in order to make it more meaningful.

Quarterly Report - Dec. 1972

Problems

Recurrent:
The problem of jurisdiction between the reservation and the off reservation community continues to remain. The hiring of an aide at Fort Belknap continues to be the number one priority. This is complicated by not having housing. However at this time one person who is interested in the job, and seems to be qualified, is living in the area and I would very much like to explore the possibility of hiring him.

b. Comments:

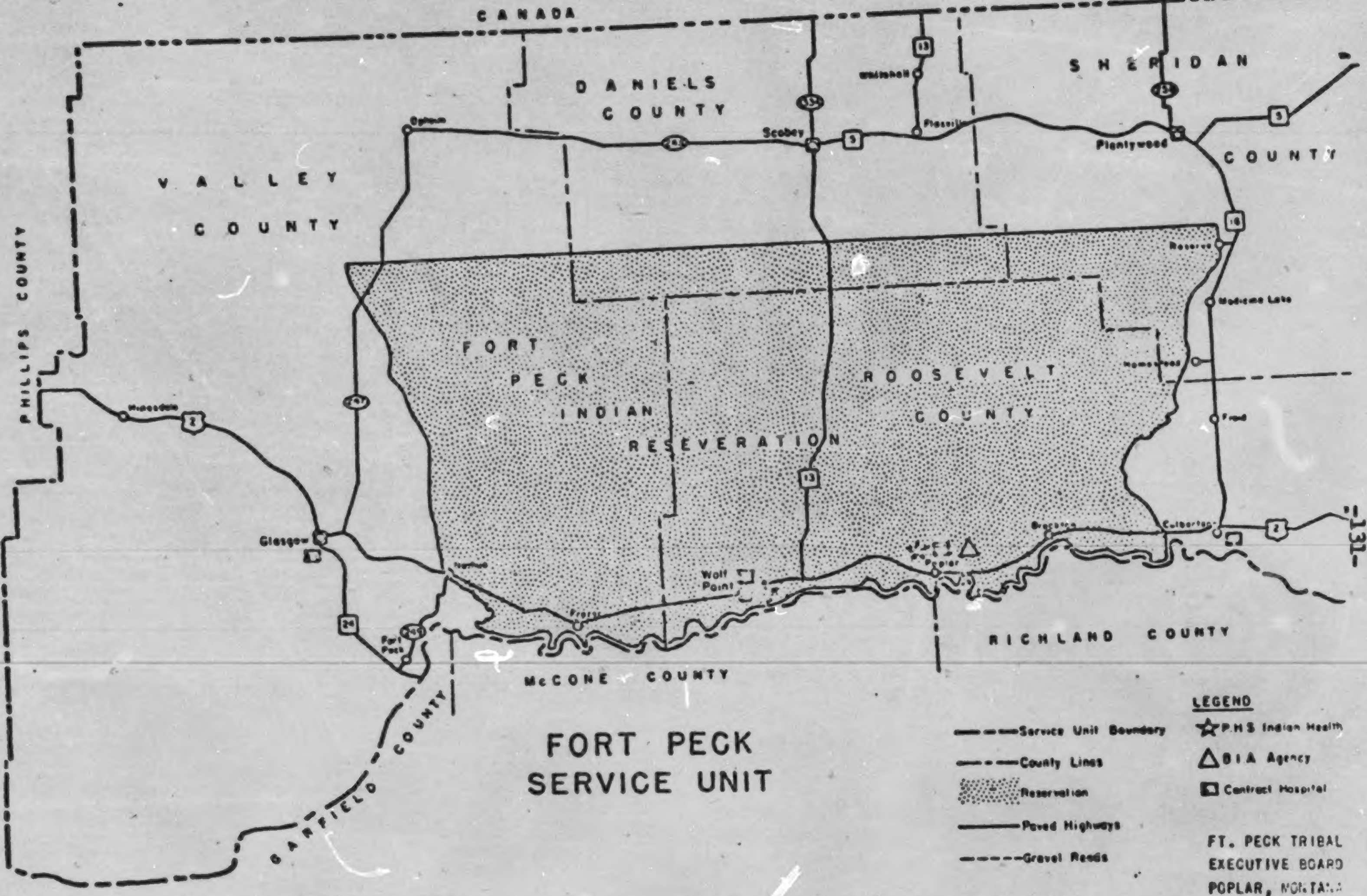
Until some such plan as contracts developed with tribal and non tribal resources become viable, it would appear that the vast territory of Fort Belknap and its lack of housing defeats most attempts to develop viable Mental Health Programs.

In 1973 the cast of characters changed slightly but the problems they struggled with remained virtually the same. As has been indicated in the discussion of the Rocky Boy's program, the solutions are not easily discovered or implemented.

One observation occurs to an outside observer. The Service Unit Hospital and Mr. Morasch's residence are both located on the northwest corner of the Fort Belknap Reservation, close to a major highway and access to the larger non-Indian towns and cities of Montana. However, almost three-fourths of the Indian population live in the southern section of the Reservation. This may be creating a communication gap which makes it difficult to stimulate community mental health interests among the local population.

These problems are not unique to the "Highline" Reservations, or even to the Billings Area, but they have been given attention because they illustrate both the frustrations and the achievements that are characteristically encountered in developing rural mental health programs.

5. Fort Peck Reservation


CANADA
DANIELS COUNTY
SHERIDAN COUNTY
VALLEY COUNTY
PHILLIPS COUNTY
FORT PECK INDIAN RESERVATION
ROOSEVELT COUNTY
RICHLAND COUNTY
McCONE COUNTY
GARFIELD COUNTY
Opheim
Whitetail
Flaxville
Scobey
Plentywood
Reserve
Medicine Lake
Homestead
Froid
Culbertson
Brockton
Poplar
Wolf Point
Frazer
Nashua
Glasgow
Hinsdale
Fort Peck
LEGEND
Service Unit Boundary
County Lines
Reservation
Paved Highways
Gravel Roads
P.H.S Indian Health
B.I.A Agency
Contract Hospital

FORT PECK SERVICE UNIT

FT. PECK TRIBAL
EXECUTIVE BOARD
POPLAR, MONTANA

REV. 2/73 JR

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
FORT PECK SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			DANIELS			ROOSEVELT			SHERIDAN			VALLEY		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	609	306	303	-	-	-	430	212	218	2	1	1	177	93	84
5-14	1376	721	655	8	3	5	1030	536	494	9	6	3	329	176	153
15-24	783	354	429	-	-	-	586	272	314	7	5	2	190	77	113
25-34	417	192	225	1	-	1	316	152	164	3	1	2	97	39	58
35-44	390	196	194	-	-	-	297	146	151	3	2	1	90	48	42
45-54	309	160	149	2	1	1	246	122	124	6	5	1	55	32	23
55-64	210	109	101	4	4	-	152	75	77	8	3	5	46	27	19
65+	200	103	97	1	-	1	168	80	88	4	3	1	27	20	7
TOTAL	4294	2141	2153	16	8	8	3225	1595	1630	42	26	16	1011	512	499

---

* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

1. GEOGRAPHY:

The Fort Peck Service Unit includes all of Valley, Daniels, Sheridan, and Roosevelt Counties, which are located in the northeastern corner of the State of Montana.

The Fort Peck Reservation covers an area approximately 80 miles long and 40 miles wide. This area consists of 2,000,000 acres of rolling prairie land in northeastern Montana that was shaped by glaciers that moved as far south as the Missouri River, which forms the southern boundary of the reservation. From the broad flood plain of the Missouri, the land rises gently to the north and west and is cut by the valleys of several streams. The valleys of its Poplar River and Big Muddy Creek are broad and flat, but include areas that are rolling and broken. The higher prairies are comparatively level with gentle slopes suitable for farming. These grade into rolling hills, usually with rounded tops too steep for cultivation. There are few isolated "badland" areas, but these are not extensive. Elevations vary from 1,900 to 3,100 feet.

The Fort Peck Reservation lies in the portion of Montana that has a "Continental" type climate. Annual rain fall is low (12.72 inches) and the climate correspondingly dry. Summers are warm, but seldom oppressive. Sunny weather predominates during the warmer season, but interruptions in the form of thunder showers do occur, mostly in June and July, and in the afternoon or early evening.

Winters are quite cold. During the 30 year period from 1925-1954, an average of 46 days a year (December-February) had a maximum of 0 degrees or colder. Mild winters are not uncommon, but very cold spells occur, at least once every winter. Highest recorded temperature is 110° F and the lowest is -54° F.

Wolf Point, the largest town on the reservation, has a population of 3,095. Poplar, the second largest town on the reservation with a population of 1,389, which includes the population near the city limits, is headquarters for the Assiniboine and Sioux Tribes, the Fort Peck Indian Agency, and the Fort Peck Service Unit. Brockton, Frazer, Wiota, Riverside, Oswego, and Fort Kipp are smaller communities.

2. POPULATION:

The total Indian population in the Service Unit is 4,294. The Indian population is concentrated in the southern one-third of the reservation, along U.S. Highway #2 and the Burlington Northern Railway. The major concentrations are found in the Poplar, Wolf Point, Brockton, and Frazer communities. Refer to Population Table, page 132, for age and sex distribution of Indians served by the Fort Peck Service Unit.

6. EDUCATION FACILITIES AND LEVEL:

Indian children, at the request of tribal leaders, have attended public schools since 1935. Listed below are the School Year 1971-1972 and 1972-1973 enrollments of the various schools located on the reservation:

ELEMENTARY & SECONDARY SCHOOL ENROLLMENT

	School Year	Total Enrollment	Indian	Percent Indian
North Side, Wolf Point	71-72	247	45	14.2
(Elementary)	72-73	249	45	18.1
	73-74			
South Side, Wolf Point	71-72	265	161	60.8
(Elementary)	72-73	249	132	53.0
	73-74			
Wolf Point High School	71-72	681	106	15.6
	72-73	672	146	21.7
	73-74			
Brockton Public School	71-72	241	232	96.3
(Elementary & High School)	72-73	232	222	95.7
	73-74			
Frazer Public School	71-72	207	160	77.3
(Elementary & High School)	72-73	220	175	79.5
	73-74			
Poplar Public School	71-72	1,021	596	58.4
(Elementary & High School)	72-73	973	574	59.0
	73-74			

There are Junior Colleges located in Glendive, Montana and Williston, North Dakota. If further education is desired, the student must attend four-year institutions in Billings, Missoula, Bozeman, Great Falls or in other areas. At present, they have 140 students attending four-year institutions and 30-45 attending Vocational Technical Schools. More Indian students are graduating from High School and are leaning toward more vocational and technical education.

7. TOTAL RESERVATION HOUSING:

The Fort Peck Housing Authority has continued, during the past year, to build more housing on the reservation. They have presently completed 106 low-rent houses, 50 mutual self-help homes, and 150 Turnkey III homes.

The responsibility for communication between agencies and the Service Unit is the responsibility of the non-medical Service Unit Director and the Community Health Services Director.

11. SOCIAL-CULTURAL CHARACTERISTICS:

There has been a marked increase in the educational level of the adult population (18 years of age and older) living on the Reservation.

During school year 1972-1973, approximately 140 students are attending college as against 30 five years ago. There has also been an increase in attendance at vocational or technical schools, though not as great, with approximately 40 presently attending vocational or technical schools as against 30 five years ago.

Cultural Characteristics: The relatively high degree of assimilation of the Fort Peck Assiniboine and Sioux Indians into the dominant culture can, to a large extent, be credited to: opening the reservation for homesteading in 1911, thereby providing them early contact with non-Indian family life and culture; integration of schools nearly 35 years ago and the frequency of marriage of tribal members to non-Indians.

Evidences of assimilation include the fact that over 40 percent of the enrolled members have left the reservation and that nearly one-third of the resident population is economically on a par with non-Indians of the area.

It is estimated that about 95 percent of the Indians speak English. Dress and social activities are similar to that of the non-Indians.

Indian celebrations are still held each year. They are primarily social-recreation get togethers and have little, if any, religious significance. There are still signs of social upheaval related to cultural change. These include high drop-out rate and poor school attendance, broken homes, misuse of alcohol, and minor crimes.

Religion: A majority of the people are Protestants; however, the Catholic Church has a significant following on the reservation. There appears to be no significant remnant of Indian religion. The Native American Church has not been established on the reservation.

Organizations: There are two all-Indian women's organizations--a Home Demonstration Club and War Mother's Club. All other civic and fraternal groups, such as American Legion, VFW, PTA, and church societies are integrated. There is a fairly active AA Chapter in Poplar with both Indian and non-Indian members.

a: Mental Health Services, Training and Activities

From 1969 to 1971 a psychologist, John Iacovini, was assigned to the Fort Peck Service Unit and a Mental Health Aide position was filled in 1972 by Mrs. Rena Comes Last, and Mrs. Leonora Red Elk, employed as a secretary was given Mental Health Worker training and later promoted to full Mental Health Worker status. Mrs. Catherine Elder was selected in 1972 for training as a Social Work Associate and received clinical supervision as part of the Mental Health Team. There does not seem to have been a Social Worker attached to the Service Unit, but staff from other agencies provided in-service training and consultative sessions on a regular schedule for the Mental Health Team, the CAP program, Tribal alcoholism program and at times including Community Health Representatives.

In October, 1971, Dr. Gustafson, Area Mental Health Chief, reports one of his early impressions of a need on the Fort Peck Reservation.

> Treatment for Wayward Adolescents: In my visit to Ft. Peck, I was involved in joint interviews with two young men. One of these young men had a family stable enough for him to get along in, and the second young man did not. Both of these young men could be approached psychotherapeutically but regular psychotherapy with the second boy could not be continued because of the instability of his home situation. There just seems to be nowhere on the reservation for this young man to stay. Somehow we are going to have to develop inexpensive residential situations for these young people, so that our trained psychotherapists in the field can continue to work profitably with these young people.

Out of this need, interest developed in a group home project. This is still being pursued as a needed local resource. Liaison with Hope Ranch has been one avenue pursued as well as the development of family and other approaches than pure psychotherapy.

In April of 1972 recognition was given two of the Mental Health Workers in the Area monthly report.

> Essays by Indian Counselors: Mrs. Lenora Red Elk and Mrs. Rena Comes Last completed interesting essays as part of their work for college credit begun in our first mental health training conference. The essay by Mrs. Comes Last is entitled Basic Concepts in Orienting Framework for Psychotherapy and Counseling on the Fort Peck Indian Reservation. The essay by Mrs. Red Elk is called Traditional Dakota "Wiyaksapa" or Counseling on the Fort Peck Indian Reservation. Both essays are quite useful in their setting out of the traditional values that go into counseling. Persons interested in reading these essays may borrow copies directly from Mrs. Comes Last and Mrs. Red Elk. They will also be available to all mental health and social service personnel through the "materials channel" of our Educational Network in the mental health program.

The flavor of work on the firing line and the variety of activities these three ladies became involved with is shown in their later reports. The first report quoted is dated Narrative Report, April 1 - June 30, 1972, by Mrs. Eder:

> Mrs. Margene Dohner, Deputy Chief, Area Mental Health Service Branch, Keeneta Harris and Mr. Tony O'Dea were visitors at this service unit on May 17. They also met with the Alcoholism Counselors concerning the Thrift Shop*.
>
> A. New Activities and Experiences
>
> 1. Training:
>
> a. I attended the annual Indian Health Service Mental Health Convention at Denver from May 23 to the 26, 1972. This was an interesting experience for me, especially to meet other Mental Health workers and their perceptors.
>
> b. A one week workshop was attended at the Rocku Mountain College, Billings, Montana, on Marriage and Sexual Counseling. I felt this was a little too intellectual for me.

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* See Alcoholism Program Development pp. 71-73.

c. The Fort Peck and Rocky Boy, Mental Health Staff, met on June 14, 1972, at Fort Belknap with Dr. Gustafson. This type of workshop seems to be appreciated by all; gives us a chance to exchange ideas and feelings.

d. I also attended the workshop at Crow Agency on June 27, 1972. Dr. Jess Lair, Psychologist, from Bozeman was guest speaker. His lecture has been very meaningful and useful to me.

e. On June 28, 1972, Catherine Turcotte, Social Work Associate, Caroline Bacon, PHN Clerk, from Rocky Boy, and Lenora Red Elk and myself visited the Day Care Center at Browning.

2. Clinical:

a. One day a week is spent at the Frazer Community Hall Office for the Public Health Nursing Conferences. The people in the community are coming in but they still don't understand what I am doing.

b. I have been making home visits on referral from Mr. Iacovini, Psychologist, and the Medical Doctors. A visit to the Wolf Point Health Center and Poplar Health Center is made each week to keep in contact with them.

3. Community Development:

a. I have been attending the alcoholism meetings each Tuesday evening, providing transportation for ladies who wish to attend.

b. I also have been working with the Indian Boy Scout Troop sponsored by the Fort Peck Tribes. This itself takes a lot of time especially on weekends if they decide to have camp-outs; but is fun. Our committee meets one day a month with one board member to keep them informed of the activities.

B. Needs

1. More office space since our staff is growing.

2. Government vehicles assigned to Mental Health to be left at office.

Mrs. Catherine Eder

Mrs. Red Elk lists the same training experiences as Mrs. Eder, but describes her somewhat different activities and focus:

2. Clinical:

   a. Sixty visits were made to clients and to our office by our clients for the period of April 1 through June 30, 1972.

3. Community Development:

   a. Participated in an alcoholism workshop on our reservation on April 4, 5, and 6, 1972. I felt that it accomplished two things: It made the community aware of alcoholism and aware that a Counseling Center was here and that it was a place to go when help was needed with problems concerning marriage, drinking, drugs, growing up and just every day pressures of living.

   b. Have attended seven meetings on day care. Involved in getting a day care center started here.

B. Special Accomplishments:

   a. Completed a years training with the Western Region Indian Alcoholism Training Center in Salt Lake City, Utah in March, 1972. Graduation exercises were held on the Fort Peck Indian Reservation on May 26, 1972 for six of us.

C. Problems:

   1. Recurrent: being disorganized.

D. Needs:

   1. None

E. Ideas:

   1. None

Lenora C. Red Elk

Through roughly the same period of time Mr. Iacovini summarizes his own activities (April 15 - August 11, 1972) as he prepared to leave for additional graduate work.

2. Clinical:

   a. The following number of sessions were conducted with clients in these primary areas:

      1) Psychosis - 3
      2) Adolescent identity and childhood behavior problems - 29
      3) Suicidal - 16
      4) Marriage counseling - 19
      5) Depressive neurosis - 30
      6) Alcoholism - 18
      7) Family counseling - 7
      8) Vocational counseling - 2

3. Community Development:

   a. Numerous planning meetings with the Hope Ranch Tribal Project Staff. Also I have been involved in helping Hope Ranch Staff members with personal and interpersonal staff problems. I believe our relationship with the project is quite positive. I believe we are regarded as a worthy helping agency to the project and I have committed our center to provide the major direct services for clients involved.

   b. Numerous meetings have taken place with those involved in the Thrift Shop Alcoholism Project. My role has been as a consultant. We have thus far been able to work through problems which occurred. However with the departure of Linda Iacovini, who assumed the major leadership role, the impetus of the program may be in jeopardy.

B. Special Accomplishments:

Being instrumental in securing a contract position for Mr. Charles Trinder, Indian Mental Health Consultant. Our working relationship is quite positive and he has provided effective direction to the center's operation.

C. Problems:

1. Internal structuring of the staff members activities and supervision.
   However the recent visit on August 2 and 3, 1972 of James P. Gustafson, M.D. was quite helpful

and served as a valuable training experience for me. This visit enabled us to see the issues of this problem more clearly. Since the visit I have made active attempts to structure the program more effectively. In the past several weeks I believe the results have been positive. It is evident that internal structuring of activities, supervision and training for staff members must be a high priority. The attempts in the last few weeks have only been a beginning and indicate more specific issues which must be dealt with. After I leave on August 18 it is urgent that the internal structuring of time and activities be carried on.

D. Needs:

1. The counseling center has acquired a trailer for its new location away from the jail. This has been accomplished largely through the efforts of Charles Trinder and mostly Russell Van Tine.

The needs for the trailer are:

a. Two phones with separate lines.
b. Furniture more suitable to the trailer space.
c. A locked file cabinet. Several requests for this have been made to no avail.
d. A Counseling Center sign outside the trailer.

Other needs:

a. Technical assistance for Charles Trinder while I am gone or till my position is filled.
b. An even closer relationship with the clinic staff and hospital staff.
c. An adequate suicide attempt register.
d. A more adequate record keeping system for client session, BAO communications, community involvement projects, etc.
e. Organizing an educational network workshop here.
f. More intensive training, weekly structured activities and caseload build-up for several members of our staff.
g. A closer relationship through Gordon Wilson, Community Health Director.
h. A consulting contract with the Glasgow Mental Health Center and a means to use their time here more effectively.

The trailer mentioned as having been procured meant that this staff could move from previous quarters in a local unused jail. However, reports over the next few months emphasize that this was not an unmixed blessing. After the formal "Open House" in September one problem repeatedly recurring was the lack of a sign to identify the unit as requested as early as the substitution was planned. How this problem was solved is never clear but for six or eight months clients often sought them in the old quarters or gave up and most initial contacts were made in home visits.

The trailer offices, although visually attractive, needed a smaller scale of furniture than the standard government issue. These offices also were not sound proof, which inhibited the intimate discussions required until one of the women hit upon the idea of using radios to mask the voices - an idea that must have made the teenagers and their families feel at home.

The New Careers program permitted the addition of another Mental Health Aide and provided some other supports. Mr. Charles Trinder, with a background in counseling, became the official consultant to the program, and a contract for training, consultation, and back-up clinical services was executed with the Glasgow, Montana, CMHC.

The quarterly reports continue to show an enthusiasm for training opportunities, the details of the work being done, and a lively sense of the humor and personalities of the two women who as mental health workers were on the firing line in the delivery of services.

The following copy of Mrs. Red Elk's narrative reports for the end of September 1972 give the flavor of this period:

A. New Activities and Experiences

1. Training:

   a. We began our weekly in-service training sessions on July 6, 1972. It has been a lot of help to us because we are getting actual experience through role playing. We each get a chance to make a presentation on what ever we feel can be of help to all of us in working with our people. Then, too, we have resource people come in and present their ideas on how they work with people. We recently had Robert Swan, Field Coordinator, from the University of Montana come in and make a presentation. We learned some techniques in group counseling. The New Careers people became interested in our in-service training sessions and asked if they could join us. They will also get a chance to prepare a presentation.

   b. Margene T. Dohner, Deputy Chief of Mental Health, visited us on August 29, 30, and 31, 1972. While she was here she gave her presentation on a problem-oriented record.

   c. Attended a field seminar at Crow Agency on August 14 and 15, 1972. In this seminar the counselors presented cases which they felt they needed help with and we were able to give suggestions to them on what we would have done in a similar case that we had had.

      A presentation was made on community organization. It helped me to realize that I was not really utilizing all of our resources.

2. Clinical:

   a. Out of a total of seventy-eight visits, eight were office visits and the remaining seventy-two were home visits.

      Home visits help me to realize how the person must feel when coming in to see me. I know what makes me feel comfortable in their homes and what does not. It helps me to understand better how they feel and what I should do to make them comfortable when they come in.

3. Community Development:

   a. Participated in the planning and putting on of a workshop on our reservation on September 20 and 21, 1972. Our guest speakers were Audra Pambrun, Marie Williamson, and Eileen Pepion from Browning, Montana. Audra Pambrun has had much success in getting a crisis intervention center going on her reservation. We sent invitations out to the Billings Area people but they were unable to come because of a number of reasons. It was felt to be a great success for we had a lot of local participation. During the workshop we learned about what we could say or do to prevent someone from attempting suicide. We did this through role playing and by Audra telling of her actual experience and what she had done.

   b. I am still attending day care center meetings. We were told that we would have to become incorporated before we could start making plans. To date we are havibg a charter being drawn up. To have this done we have to pay a fee. We have had a food sale to pay for this service.

B. Special Accomplishments

1. We held an open house at the new location of our Indian Health Counseling Center on September 29, 1972. We had quite a nice turn out. I feel that the people who came were enlightened as to what we do here.

C. Problems

1. New: getting involved in too many activities.

D. Needs

1. Our need in this office is a copy machine.

2. Have our offices made sound proof. Or maybe we can get radios for offices and have them going when we talk to a client.

3. A sign on the outside of our center so people will know where we are. We wrote a requisition for one back in June, 1972.

E. Ideas

1. None at the present

Lenora C. Red Elk

By January 1973 the Day Care Groups had become incorporated but by late April 1973 it had hit financial and other snags that local bake sales could not remedy. Mrs. Red Elk reports, " To date (April 20th) our day care center plans are at a standstill. This proposal has everyone stumped." Since subsequent reports are not available, the ultimate fate of this project is not known.

In the January report, covering October 1 through December 31, 1972, Mrs. Eder is particularly graphic in presenting both her own and her clientele as real people. Excerpts are quoted below:

> c. Dr. Jim Gustafson, Chief, Mental Health, was here on October 4th, 5th and 6th. He conducted the in-service training while here on Marriage Counseling which was very interesting and helpful. I also had the opportunity to sit in on a session with him and a patient at the Wolf Point Hospital. A forty-one year old Indian female who was admitted for Hysterical Depression. This lady had been visited by Mrs. Red Elk prior to her admission and was being followed by her upon returning to duty. Unfortunately, this person passed away on January 8, 1973. An autopsy was performed to determine cause of death. There is a possibility of an overdose.
>
> 2. Clinical:
>
> a. Due to snowy cold weather and my being on leave after having two minor operations, hepatitis in my family and the loss of my father, home visiting has been hampered.
>
> b. One big problem here is getting clients to come to our office. Most of my visits have been suicide attempts, alcohol related.
>
> c. One 17 year old Indian female expired on October 2nd after taking an overdose of diabetic pills. A psychological autopsy was attempted but never completed. A taped interview was done by myself and the grandmother who she lived with since the separation of her parents.
>
> d. Friday afternoon of each week are spent at Frazer. Plans are made to visit the school there each Friday also.

3. Community Development:

   a. No new Development

At the end of February, 1973, Mr. Trinder summarized the staff's activities. In its matter of fact listing it underplays the drama of staff activities, the multiplicity of demands on the staff, and the annoyance of continually being unable to solve perennial "housekeeping details," such as car pool keys and garbage disposal. For anyone with field experience this report rings true and the information "between the lines" reveals a lively and vital program.

February 27, 1973

Counselor, Consultant, Indian Health Counseling Center, Poplar, Montana
Through: Community Health Director
Monthly Progress REport for Mental Health, January 26 to February 25, 1973

Service Unit Director, PHS Indian Health Center, Poplar, Montana

The end of January and most of February saw a lot of after hours work being done in suicide attempt follow-up and crisis intervention. This counseling was performed at the Poplar Hospital, the PHS clinic, and at individual's homes. Follow-up work is continuing with these clients.

The flu took its toll during the past month, as we all spent some time at home to combat it. During this time we shared the responsibility of seeing each others clients and arranging new appointments for our clients.

The ladies in the office are continuing to meet on Tuesday evenings with the local A.A. group and take them to the meetings with them.

Calvin First, Lenora Red Elk and Charles Trinder attend the weekly staff meetings at the Half Way House. This gives them the opportunity to consult with the alcoholism counselors and to keep up dated on what is happening in their area. It also provides an excellent opportunity to effect a better working relationship between Mental Health and the Alcoholism Program.

Mrs. Red Elk attended a week training session sponsored by the Kellogg Extension Education Project on group communications. This was held at MSU at Bozeman, Montana. It gave her the opportunity to learn how to use community and other resources to get community sponsored activities started and how to work together to solve their problems. Catherine B. Eder will be attending the same conference in March. This conference was at no expense to the government.

Lenora Red Elk was invited to speak to classes in Brockton School on teenage alcoholism and its prevention. According to Miss Johnson, the school counselor, Lenora did a very good job.

Catherine B. Eder was called upon in the past month to talk to individuals in the hospital on suicide attempts. She is continuing to do followup work with these clients.
Glasgow Mental Health continues to visit our office each Thursday. In addition to working directly with clients and consulting to us on our cases, Aldine Taylor has been teaching in-service training to our counselors and the New Careers counselors.

In-service training has continued to be held on Thursday mornings. We are utilizing all resource people available in our area to particpate and they often teach for a period of time.

Calvin First is presently attending a two week drug abuse course in Minneapolis, Minnesota, called "Help the Community Help Themselves." Calvin was sent by the New Careers program and will share his knowledge with our in-service training program when he returns.

Dr. D. J. Doland, Clinical Psychologist from Smith College, Northampton, Massachusetts, is here for two months to consult to our office and other agency offices and also to provide some community education courses. Dr. Doland has agreed to teach group counseling and other selected topics to our in-service training program.

Charles Trinder and Calvin First have been making regular Monday afternoon consultations to the Brockton schools. They are working closely with Dorothy Johnson, the high school counselor.

Dr. Doland and Charles Trinder discussed the possibility of receiving college credit for the training that Dr. Doland and the counseling center has been providing. This was discussed with Mr. James Limberg. Mr. Limberg was to contact Dawson Junior College on this matter. At this time nothing for certain has been decided.

Catherine Turcotte, Social Work Associate, from Rocky Boy spent a week with us on a poor matching program. She worked closely with Catherine B. Eder and attended all of our meetings and training sessions.

Dr. Gustafson spent two days consulting to Mental Health and various agencies. He also presented a session on glue sniffing to our in-service training program.

On several occasions we have asked to be included on the distribution list for a copy of the admission sheet from the hospitals* so that we make sure we contact all clients seen for mental health problems. This has not yet been provided for us.

We would like to have a set of keys for one GSA car left at our office for evening and weekend calls. Sometimes it is very difficult to get a car on weekends and in the early morning hours. The car would remain parked at the clinic parking lot and the keys could be locked in our record cabinet.

With janitorial staff being cut to a minimum, we would like to have a garbage set behind the counseling center.

As a final summary, this excerpt from the Service Unit Profile for December, 1973, succintly describes the current status of the Fort Peck Mental Health Program:

> Mental Health: The Indian Mental Health Counseling Center has four counselors. The general types of counseling services provided are: family difficulties, adolescent counseling, marriage counseling, suicide preventior, crisis intervention, counseling during periods of anxiety and depression, counseling during periods of disorientation and hallucinations, problems related to child neglect, counseling during problem pregnancies, counseling during periods of legal or court involvement, educational difficulty, counseling when work and employment difficulties arise, and family counseling after the loss of a family member or loved one. Psychological testing and evaluation is available on request and is performed by the Glasgow Mental Health Center.
>
> Counseling sessions are performed by the client coming to the mental health offices or by a mental health worker making a house visit. Visits are quite often made to individuals in the jails and in the hospitals.

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* All hospitals used are contract care facilities.

Consultation services are provided to the following organizations or services:

Hope Ranch: Consultation services are provided to the director, family counselor coordinator and house parents. Direct patient services are provided to the children at Hope Ranch and to their natural parents upon request of the Hope Ranch staff.

Alcoholism Program: Consultation services are provided to the alcoholism counselors upon request. Direct patient services are given to alcoholics and their families when requested by an alcoholism staff member.

Public Schools: Consultation services are provided to the counselors, teachers, and administrators upon request. Direct patient services are provided to individual or groups of students when requested by one of the staff members.

New Careers Program: In-service training is provided for the new careers counselors on a weekly basis. Consultant services are available at the new careers counselor's request.

Other agencies: The Mental Health Team provides consultant services to other Tribal, Bureau of Indian Affairs, and Public Health Agencies upon request.

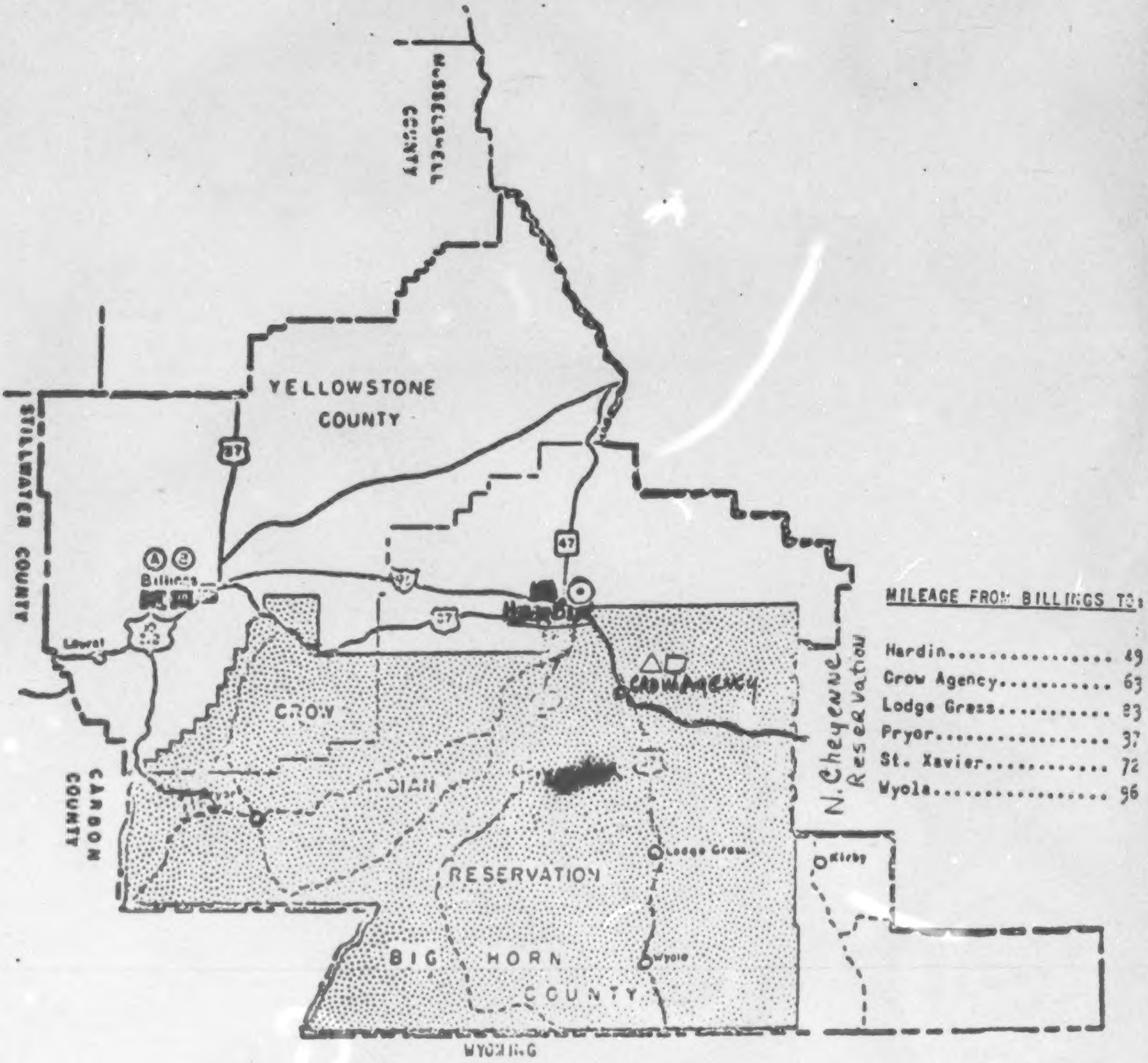
b. Comments:

It is difficult to close off this description of the Mental Health Program at Fort Peck. However, it has continued to grow and develop as have the two on the staff. Their subsequent reports reveal that they can not only take Transactional Analysis Workshops in stride but that they can also utilize the material from such sessions in local programs. They continue to visit resources and agencies utilized by the tribe and to pursue reciprocal involvement in practical projects for the benefit of the community.

If the Rocky Boy - Fort Peck programs illustrate the problems faced by rural reservation Mental Health Programs, Fort Peck would seem to illustrate the other side of that coin. On Fort Peck the use of contracts to promote local programs (Alcoholism Thrift Shop) and to secure needed liaison with clinical services (Glasgow Mental Health Center) together with careful recruiting and regular training input have produced a viable Mental Health Program.

6. Crow Reservation

CROW SERVICE UNIT


MUSSELSHELL COUNTY
YELLOWSTONE COUNTY
STILLWATER COUNTY
CARBON COUNTY
Ⓐ Ⓑ
Billings
Laurel
87
47
212
CROW INDIAN RESERVATION
Hardin
CROW AGENCY
Pryor
Lodge Grass
Wyola
Kirby
BIG HORN COUNTY
N. Cheyenne Reservation
WYOMING

MILEAGE FROM BILLINGS TO:

Hardin	49
Crow Agency	63
Lodge Grass	83
Pryor	37
St. Xavier	72
Wyola	96

LEGEND

- ▬ ▬ ▬ SERVICE UNIT BOUNDARY
- — - — COUNTY LINES
- ▨ CROW RESERVATION
- ——— PAVED HIGHWAY
- - - - - GRAVEL ROADS

- ◎ BIG HORN COUNTY HEALTH DEPARTMENT
- ■ CONTRACT HOSPITAL
- □ PHS INDIAN HOSPITAL
- ● PHS INDIAN HEALTH STATION

- Ⓐ BILLINGS AREA OFFICE IHS
- Ⓑ BILLINGS AREA OFFICE BIA
- △ BIA AGENCY

CROW TRIBAL COUNCIL
CROW AGENCY, MONTANA

REV. 12/72 JR

1. GEOGRAPHY:

The Crow Indian Reservation is located primarily in Big Horn County of south central Montana. The Reservation is approximately sixty miles wide and forty miles in length, encompassing 1,574,394 acres.

Mountains, residual uplands, and alluvial bottoms make up the topography of the Crow Reservation. The three principal mountain areas are the Wolf Mountains on the east, and the Big Horn and Pryor Mountains on the south. Sloping downward to the north from the mountains are rolling upland plains. The plains constitute the bulk of the reservation and vary in altitude from 3,000 to 4,500 feet. The alluvial bottomlands are located along the Big Horn River, Little Big Horn River, and Pryor Creek drainage systems.

This part of Montana has a moderate climate considering its latitude. Snow seldom accumulates for extended periods of time because of the warm chinook winds which blow from the mountains in the west. This portion of Montana enjoys "Indian summers" which frequently extend into November. This is a time of warm sunny days and cool evenings. The mean annual temperature is 45.5° F. with a summer high of 110° F. and a winter low of minus 48° F. The bulk of the reservation varies from twelve to eighteen inches annual precipitation, depending on the elevation.

Principal settlements are Lodge Grass, Wyola, Pryor, St. Xavier, and Crow Agency. Lodge Grass, Hardin, Billings, Montana, and Sheridan, Wyoming are principal trade centers. Wyola, on the southern end of the reservation and Pryor in the western portion, are the most isolated communities. Most reservation residents consider Crow Agency the parent community since it is the industrial center and the location of federal agencies and tribal offices. The following are the distances from reservation communities to Crow Agency: Hardin 13, Lodge Grass 20, Wyola 33, St. Xavier 25, and Fort Smith 45 miles. Pryor is 74 miles from Crow Agency, but when the road which is under construction between Pryor and St. Xavier is finished, this distance will be 20 miles shorter.

2. POPULATION:

The bulk of the reservation population lives on the eastern side of the reservation, in the Little Big Horn River Valley, from Wyola to the outskirts of Hardin.

Smaller segments of the population live in the Big Horn River Valley between Fort Smith and Hardin, in the Pryor Creek Valley, and in cities adjacent to the reservation.

From the 1960 to the 1970 Census, the on-reservation Crow Indian population had increased 16.2 percent. During the same ten-year period, the Montana Indian population increased 28.0 percent and the Montana non-Indian population increased 2.0 percent.

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
CROW SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			BIG HORN			YELLOWSTONE		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	591	284	307	423	200	223	168	84	84
5-14	1415	712	703	1126	554	572	289	158	131
15-24	876	407	469	605	279	326	271	128	143
25-34	553	275	278	409	205	204	144	70	74
35-44	442	200	242	349	161	188	93	39	54
45-54	311	151	160	233	118	115	78	33	45
55-64	213	100	113	178	78	100	35	22	13
65+	170	88	82	131	69	62	39	19	20
TOTAL	4571	2217	2354	3454	1664	1790	1117	553	564

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* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

The mobility pattern of the reservation population can be determined somewhat from a study of the changes in the age distribution over time. From the 1960 to 1970 census the Crow population in the 20 to 34 year age (younger working force) bracket had increased 3.3 percent, whereas the increase in population for the same age bracket in the surrounding counties (Big Horn and Yellowstone) was 9.8 and 10.2 respectively. This is indicative of a population of high outmigration. For the Fiscal Year 1973 population breakdown (1970 Census projected) by age and sex, by county, see the population table on page 153.

Social Cultural Characteristics:

Education Level: Of the adults on the Crow Reservation, 59 percent have had close to ten years of education.

Language: In a bilingual community one runs into a lot of problems in the command of language. The Crow Indians have no written language of their own or formed word construction which corresponds to English. This causes a great deal of trouble in reading and in word meanings.

Religious and Value System: In the past, during nomadic days, the Crow Indian lived in close harmony with nature. He observed its strength, received its many good blessings, and was a victim of its fury. He needed protection so he conceived a supreme power which he believed had designed all the elements about him. He symbolized these elements in rituals and ceremonies through which he offered prayers to the greater power around him. These rituals and ceremonies are still observed by many, and with deep reverence. In addition to traditional prayers and fasting, individuals and families carry medicine bundles and participate in the Sun Dance, Tobacco Dance, Sweat Lodge, Feast Ceremonial, etc. The social, cultural, and religious (value) systems of the Crow Indian are based on ancient native philosophical beliefs and are perpetuated through traditions, customs, legends, myths, and clan systems.

Tribal Government: Under its constitution, the Crow Indian Tribe has a general council form of government in which every adult enrolled member is allowed to vote, if they are present during the meeting of the general council. This council has the authority to present, act, and speak for the Tribe in any and all matters, and to promote the general welfare of the Tribe and its members. The expenses of operating the Tribal Government and Tribal programs are paid for out of income received for land leases, oil and gas royalties and bonuses, and interest on funds deposited with the U. S. Government.

Education Facilities and Level:

No Federal schools have operated on the Crow Reservation since 1920. In spite of attendance in public schools with non-Indians, relationships have been handicapped by the fact that many Crow children do not speak English when they enter school. There is an educational lag in school, doubtlessly associated with this language handicap, which also appears to be a factor in Indian students dropping out of school before completion of the eighth grade or high school. The number continuing through high school and beyond has increased in recent years.

The drop-out rate is a very intangible element in school attendance. The Bureau of Indian Affairs Education Specialist believes that 12 percent, which is a percentage that has been used as an average, is a very conservative figure. He estimates that this is closer to 20 percent.

There are 1,452 young members of the Crow Tribe attending schools located on or adjacent to the reservation. Of these, 145 are attending mission schools located on the reservation. Approximately 291 students are attending off-reservation schools as shown in the chart below:

School	Attendance
Off-Reservation Boarding School (IA)	87 (2 elementary & 85 high school)
Off-Reservation Mission	25 (est.)
College, including Haskell Junior College	178
Private Prep Schools	1
Total	291

The charts on pages 156 through 160 show a breakdown of the total student enrollment by grade for Fiscal Year 1973 on the Crow Reservation.

TOTAL STUDENT ENROLLMENT BY GRADE - FY 73

Crow Reservation - Crow Agency, Montana
Number of Schools - 9

GRADE	INDIAN	NON-INDIAN	TOTAL CENSUS BY GRADE	PERCENT INDIAN
Headstart	51	9	60	85.0
Kindergarten	85	59	144	59.0
1	148	99	247	59.9
2	108	100	208	51.9
3	120	103	223	53.8
4	106	108	214	49.5
5	113	118	231	48.9
6	110	111	221	49.8
7	103	114	217	47.5
8	84	119	203	41.4
9	75	112	187	40.1
10	63	99	162	38.9
11	53	105	158	33.5
12	62	81	143	43.4
Ungraded Class-rooms - Pryor	127	3	130	97.7
Special Education Classes	44	14	58	75.9
TOTAL	1452	1354	2806	51.7

SCHOOL ENROLLMENT CENSUS: September 15, 1972 SERVICE UNIT: CROW

GRADE	HARDIN PUBLIC SCHOOL Hardin, Montana				FORT SMITH SCHOOL Fort Smith, Montana				CROW AGENCY PUBLIC SCHOOL Crow Agency, Montana			
	Indian	Non-Ind.	TOTAL	Percent Indian	Indian	Non-Ind	TOTAL	Percent Indian	Indian	Non-Ind.	TOTAL	Percent Indian
Hd. St.												
K	8	46	54	14.8	3	4	7	42.9	34	2	36	94.4
1	17	68	85	20.0	5	5	10	50.0	54	8	62	87.1
2	14	70	84	16.7	2	11	13	15.4	38	3	41	92.7
3	16	77	93	17.2	2	8	10	20.0	36	5	41	87.8
4	14	76	90	15.6	3	6	9	33.3	27	8	35	77.1
5	18	79	97	18.6	4	10	14	28.6	20	9	29	69.0
6	10	80	90	11.1	2	1	3	66.7	27	12	39	69.2
7	36	105	141	25.5								
8	32	101	133	24.1								
9	24	96	120	20.0								
10	21	84	105	20.0								
11	20	88	108	18.5								
12	21	72	93	22.6								
Spec.Educ. Elementary	9	8	17	52.9					13	0	13	100.0
Spec.Educ. Secondary	4	5	9	44.4								
TOTAL	264	1055	1319	20.0	21	45	66	31.8	249	47	296	84.1

SCHOOL ENROLLMENT CENSUS: December 13, 1972 SERVICE UNIT: CROW

GRADE	LODGE GRASS PUBLIC SCHOOL Lodge Grass, Montana				ST. XAVIER MISSION St. Xavier, Montana				WYOLA PUBLIC SCHOOL Wyola, Montana			
	Indian	Non-Ind.	TOTAL	Percent Indian	Indian	Non-Ind.	TOTAL	Percent Indian	Indian	Non-Ind.	TOTAL	Percent Indian
Hd. St.	19	3	22	86.4	16	5	21	76.2	10	1	11	90.9
K	24	6	30	80.0					5	1	6	83.3
1	38	9	47	80.9	19	0	19	100.0	15	1	16	93.8
2	22	6	28	78.6	17	0	17	100.0	13	2	15	86.7
3	32	4	36	88.9	24	0	24	100.0	10	1	11	90.9
4	27	11	38	71.1	23	0	23	100.0	12	2	14	85.7
5	33	9	42	78.6	28	0	28	100.0	10	2	12	83.3
6	39	8	47	83.0	20	0	20	100.0	12	1	13	92.3
7	29	0	29	100.0	22	0	22	100.0	16	3	19	84.2
8	22	2	24	91.7	21	0	21	100.0	7	2	9	77.8
9	46	5	51	90.2								
10	33	6	39	84.6								
11	30	8	38	78.9								
12	29	1	30	96.7								
Spec. Educ. Age 5-11	8	0	8	100.0					9	1	10	90.0
TOTAL	431	78	509	84.7	190	5	195	97.4	119	17	136	87.5

SCHOOL ENROLLMENT CENSUS: September 30, 1972 SERVICE UNIT: CROW

GRADE					PRYOR ELEMENTARY SCHOOL Pryor, Montana				ST. CHARLES MISSION Pryor, Montana			
	Indian	Non-Ind.	TOTAL	Percent Indian	Indian	Non-Ind	TOTAL	Percent Indian	Indian	Non-Ind.	TOTAL	Percent Indian
Hd. St.					6	0	6	100.0				
K					11	0	11	100.0				
					8	0	8	100.0	8	0	8	100.0
2			Primary Level		8	0	8	100.0	8	0	8	100.0
3					6	1	7	85.7	8	0	8	100.0
4					9	2	11	81.8	12	0	12	100.0
5			Upper Level		10	0	10	100.0	13	0	13	100.0
6					5	0	5	100.0	16	0	16	100.0
7					8	0	8	100.0				
8					8	0	8	100.0				
9												
10												
11												
12												
Spec. Educ. Classes					1	0	1	100.0				
TOTAL					80	3	83	96.4	65	0	65	100.0

SCHOOL ENROLLMENT CENSUS: September 30, 1972 SERVICE UNIT: CROW

GRADE	EDGAR PUBLIC SCHOOL Edgar, Montana											
	Indian	Non-Ind.	TOTAL	Percent Indian	Indian	Non-Ind	TOTAL	Percent Indian	Indian	Non-Ind.	TOTAL	Percent Indian
Hd. St.												
K												
	0	8	8	0								
2	2	8	10	20.0								
3	0	8	8	0								
4	0	5	5	0								
5	0	9	9	0								
6	0	9	9	0								
7	0	6	6	0								
8	2	14	16	12.5								
9	5	11	16	31.3								
10	9	9	18	50.0								
11	3	9	12	25.0								
12	12	8	20	60.0								
TOTAL	33	104	137	24.1								

a. Mental Health Services

The Mental Health Services have been provided to the Crow Reservation since the initiation of consultation contracts in 1963; and since the first staff hired with IHS Mental Health Programs budget were assigned to the Crow Agency(See pp. 14-23), it is quite interesting to see how this program is presented in the Service Unit Profile of December 1963. The following paragraph is quoted from that report:

> A wide variety of services are available at the Mental Health Clinic. Individual and group therapy by a Psychiatric Social Worker, Psychiatric Nurse, and Mental Health Counselor are available on a full-time basis as well as psychiatric consultation from two visiting psychiatrists. In addition to direct patient care, the staff offers consultation to schools, hospital staff and a wide variety of their community agencies. A great deal of emphasis is directed toward the major mental health problems currently existing on the reservation. These problems, which include alcoholism, suicide, emotionally disturbed children, and marital breakdown, seem to respond best to total approach consisting not only of direct patient counselling but community organization effort to change the disruptive environmental forces.

In addition to the Mental Health Program the Service Unit Profile also highlights the various programs dealing with alcoholism, which receive consultation and other services from IHS through contractual arrangements and inter-agency coordination.

> Alcoholism Counselors: At the present time, there are four trained Crow tribal members hired by the Crow Tribe who provide counseling for alcoholics on the Crow Reservation. Currently the hospital provides an office for one of the alcoholism counselors and a good share of the program is coordinated out of this office, particularly that portion of the program which deals with PHS. This program was effective in working with the PHS, BIA and the Inter-Tribal Alcoholism Program in establishing a half-way house on the Crow Indian Reservation.
>
> Halfway House: A half-way house has recently been established on the Crow Reservation and is the result of joint efforts by Crow Tribal Alcoholism Program, Inter-Tribal Alcoholism Treatment Program, Sheridan, Wyoming, PHS and BIA. PHS provided plumbing and sanitation facilities, some furniture and paint in helping to renovate the building. The Inter-Tribal Alcoholism Treatment Center currently pays the salary of one field representative who operates the halfway house.

Inter-Tribal Alcoholism Treatment Center: The Inter-Tribal Alcoholism Treatment Center at Sheridan, Wyoming, was established through the joint efforts of the Crow, Cheyenne, Arapahoe, and Shoshone Tribes, Indian Health Service, Veterans Administration and National Institute on Alcoholism and Drug Abuse. This program provides needed inpatient care for Indian alcoholics who reside in the United States. However, it principally serves the intermountain states and midwestern states. A close working relationship exists between this program and PHS facilities on reservations in Montana and Wyoming.

School consultations are not a major Mental Health team activity on the Crow Reservation. However, a psychologist who is on the staff at St. Labre's Mission does make some effort to establish consulting relationships with IHS Mental Health staff. He has not only responsibilities to satellite parochial schools at St. Xavier and St. Charles Missions, but also serves on request any Indian child or family who are referred or request his services.

A Rehabilitation Counseling Service has been recently developed under Tribal contract and is coordinating its efforts with the Crow Mental Health Team. The counselor, a mature Crow woman, is very helpful in bridging cultural gaps and has an express interest and concern in her clientele.

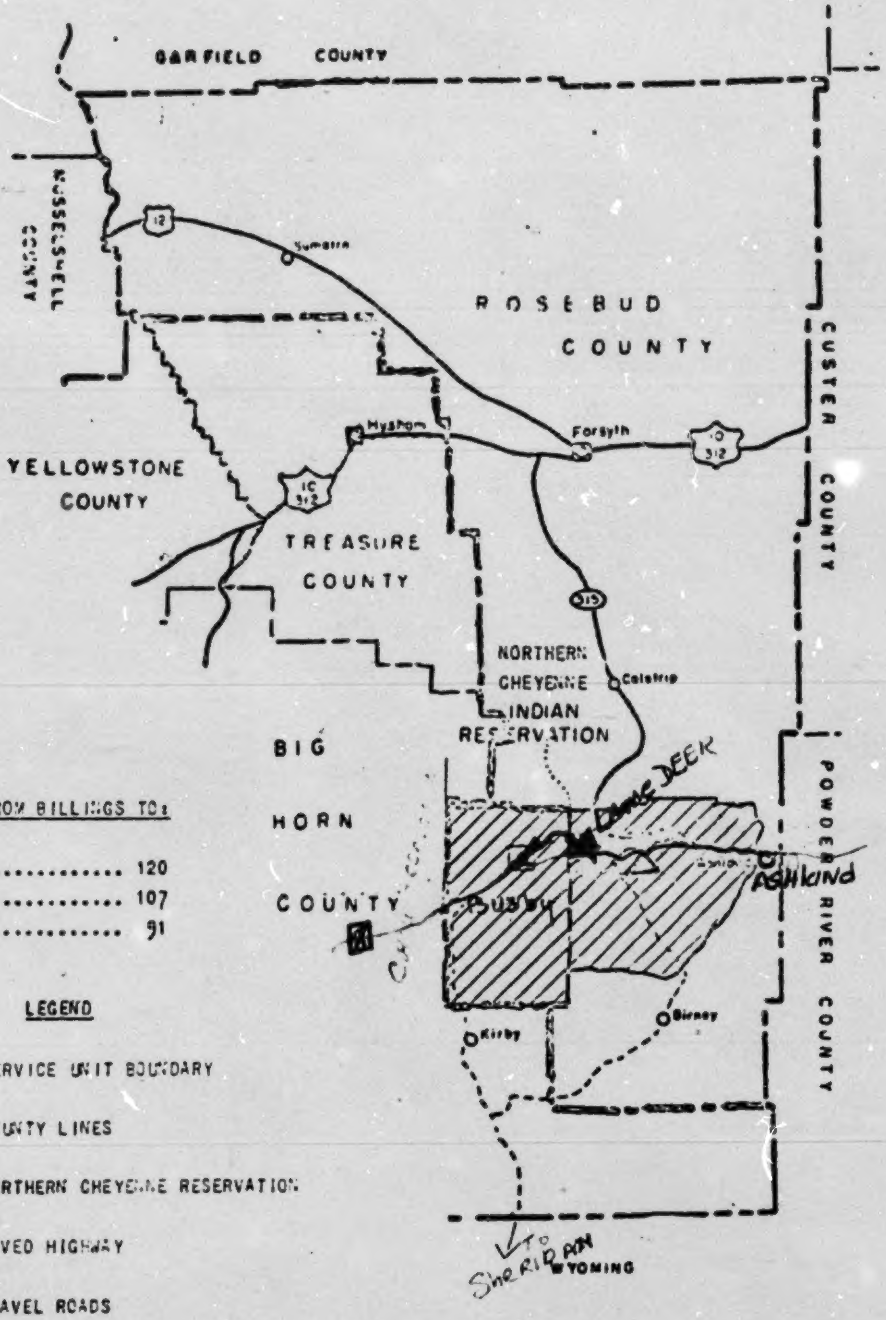
Although located on the grounds of a 34 bed hospital serving both the Crow and Northern Cheyenne, communication and program development between the two reservations is minimal. When disturbed patients are admitted from Lame Deer and the Northern Cheyenne Reservation, the Mental Health team at Crow Agency takes responsibility until discharge. They also may pick up cases from the families attending the Hospital for medical reasons and make referrals back to the Northern Cheyenne Mental Health team for follow-up.

One of the outstanding characteristics of the Crow Mental Health team on this unit is their close solidarity. Two of them, Elinor King, R.N., and Lamar Beatty, M.S.W., worked together at a state hospital in California during its phasing in of community Mental Health services, and therefore brought much appropriate experience to their IHS tasks. They closely coordinate the Social Work and Mental Health units, and have arranged to recruit a Mental Health Counselor with a B.A. degree to work with them.

One is impressed with the fact that this is a hospital based Mental Health team. There are very close working relationships with the physicians. Three days a week one of the staff makes rounds with the doctors, seeing general medical patients as well as mental health admissions. This routine and the resulting familiarity with hospital staff enable the Mental Health team to make recommendations for handling the various emotional tensions that occur around any hospitalization, as well as to work with the families of patients in these times of stress. One member of the Mental Health team is available at all times for emergencies arising in the hospital or its clinic that involve emotional crises, whether or not the primary diagnosis is in the mental health categories.

7. Northern Cheyenne Reservation

NORTHERN CHEYENNE SERVICE UNIT


GARFIELD COUNTY
MUSSELSHELL COUNTY
12
Sumatra
ROSEBUD COUNTY
CUSTER COUNTY
Hysham
Forsyth
10 312
YELLOWSTONE COUNTY
10 312
TREASURE COUNTY
315
NORTHERN CHEYENNE INDIAN RESERVATION
Colstrip
BIG HORN COUNTY
LAME DEER
Ashland
ASHLAND
Busby
POWDER RIVER COUNTY
Kirby
Birney
TO SHERIDAN WYOMING

MILEAGE FROM BILLINGS TO:

Ashland	120
Lame Deer	107
Busby	91

LEGEND

▬ ▬ ▬ SERVICE UNIT BOUNDARY

— — — COUNTY LINES

▨ NORTHERN CHEYENNE RESERVATION

━━━ PAVED HIGHWAY

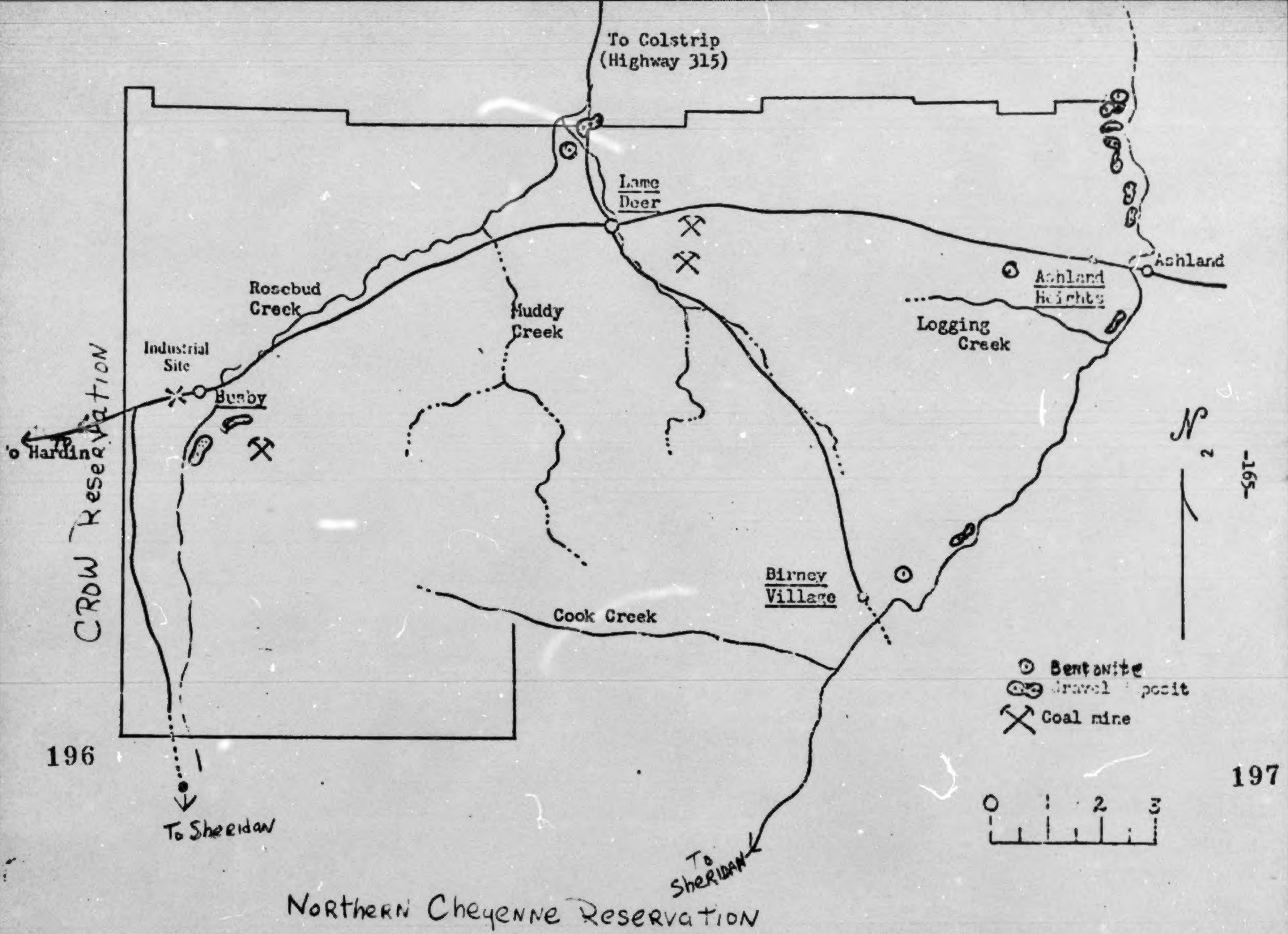
┄┄┄ GRAVEL ROADS

△ BIA AGENCY

☆ PHS INDIAN HEALTH CENTER

NORTHERN CHEYENNE TRIBAL COUNCIL
LAME DEER, MONTANA

REV. 2/73 JR


To Colstrip
(Highway 315)
Lame Deer
Ashland
Ashland Heights
Logging Creek
Rosebud Creek
Muddy Creek
Industrial Site
Busby
To Harding
CROW Reservation
Birney Village
Cook Creek
To Sheridan
To SHERIDAN
N
Bentonite
Gravel deposit
Coal mine
0
1
2
3
196
197
NORTHERN Cheyenne Reservation

1. GEOGRAPHY:

The Northern Cheyenne Reservation is located within the boundaries of Rosebud and Big Horn Counties in southeastern Montana. The topography of the reservation varies from grass-covered low rolling hills to moderately high and steep hills and narrow valleys. Elevations on the reservation range from 3,000 feet to 5,000 feet above sea level. Much of the high elevation is covered by ponderosa pine timber.

The reservation has an average mean temperature of 46.15 degrees. The highest temperature recorded is 109 degrees and the lowest is 38 degrees below zero. Snow is somewhat damp and occasionally the roads become snow-packed and icy in places. However, the highway maintenance department keeps the roads passable throughout the winter so schools are seldom closed because of impassable roads. Each year averages 185 clear days, 102 partly cloudy and 78 cloudy days. Average relative humidity is 25 percent to 35 percent.

The Northern Cheyenne Indians originally dwelt near the Red River of the North. They met whites at an early date and were reported by the French as early as 1680. When Lewis and Clark met them in 1804, they were living on the plains near the Black Hills. They changed at about this time from an agricultural people to a typical plains Tribe.

The Cheyenne participated in the treaty making in 1825 near present Fort Pierre, South Dakota. A few years later, a large part of the Tribe decided to move southward and make permanent headquarters on the Arkansas River. The remainder continued to rove the plains near the headwaters of the North Platte and Yellowstone Rivers. This separation of the Cheyenne Tribe was recognized by the Fort Laramie Treaty in 1851.

The Northern Cheyenne joined the Sioux in the Sitting Bull War in 1876. Finally subdued, they were taken prisoners of war to Fort Reno, Oklahoma, to be colonized with the Southern Cheyenne. They went unwillingly and refused to remain. A desperate effort to escape resulted in most of the group being killed. Little Wolf and some sixty followers managed to escape to the North. Finally defeated, they were placed on their present Reservation in 1884. The original Reserve, set aside by Executive Order of President Arthur, consisted of approximately 271,000 acres between the Crow Reservation and an imaginary line ten miles west of the Tongue River. In 1900, President McKinley moved the boundary line eastward to the Tongue River which has remained unchanged.

Lame Deer area (population approximately 1,450) is the seat of tribal government, the principle reservation trading center, and the most populated reservation community. It is also the location of the PHS Indian Health Center and the Bureau of Indian Affairs.

Busby area (population approximately 500), 13 miles west of Lame Deer, is the second largest reservation community. A B I A school, service station, store (and post office), and a small factory are located here.

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
NORTHERN CHEYENNE SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			ROSEBUD			BIG HORN		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	416	207	209	307	146	161	109	61	48
5-14	747	344	403	580	276	304	167	68	99
15-24	489	229	260	341	152	189	148	77	71
25-34	310	155	155	240	122	118	70	33	37
35-44	216	117	99	171	96	75	45	21	24
45-54	192	92	100	138	66	72	54	26	28
55-64	111	59	52	80	42	38	31	17	14
65+	91	47	44	65	33	32	26	14	12
TOTAL	2572	1250	1322	1922	933	989	650	317	333

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* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

Ashland Indian area (population approximately 176), 20 miles east of Lame Deer, is situated along the Tongue River which is the reservation's eastern boundary. People in this area generally shop in Ashland, Montana, which is just outside the reservation. The St. Labre Mission School and Jewelry Factory complex are located in this community.

Rosebud-Muddy Creek area (population approximately 100) is a rural area of scattered homes and ranches situated along Rosebud and Muddy Creeks between Busby and Lame Deer.

Birney Indian area (population approximately 172), located upriver from the Ashland Indian community, and about 22 miles southwest of Lame Deer, is primarily a small unorganized residential area.

Kirby Indian area (population approximately 60), located along the upper portion of Rosebud Creek 32 miles southwest of Lame Deer, is a rural area of widely dispersed Indian ranches.

Reservation residents are within 50 to 110 miles of larger towns and metropolitan areas, such as Forsyth (population 1,873) to the north, Miles City (population 9,023) to the east, Sheridan (population 10,856) to the south, and Hardin (population 2,733) and Billings (population 61,581) to the west.

2. POPULATION:

The projected Indian population for Fiscal Year 1973 for the Northern Cheyenne Service Unit is 2,572. It is estimated that approximately 20 percent of the Indian people live in rural areas. Most of the population live within a fifty mile radius of the PHS Indian Health Center in Lame Deer and come there for medical care. See Page 167 for a breakdown of Service Unit population by age, sex, and county.

SOCIAL-CULTURAL CHARACTERISTICS:

The values of the Cheyenne people are very hard to pinpoint and there are many concepts that are valued. We will only mention a few to give a basic idea of what is involved. It can generally be agreed that the few basic concepts of most importance in working effectively with the Cheyenne people are the following:

> The value system is both materialistic and spiritualistic, with a narrowing of the gap between, gradually drawing to a close over the past years.
>
> The people are divided into these two value systems with many or very few in between in any one concept or all concepts.

Materialistic (New)	Spiritualistic (Old)
Individual	Group
Competition	Cooperation
Change Accepted	Difficult to Accept Rapid Change
Saving for Future	Sharing - Immediate
Nuclear Family	Extended Family

It is estimated that about 10 percent of the people belong to the Native American Church with a great overlapping of these people into any one of the other religious cults. The rest of the population belong to any one of the religious sects, with Catholic being among the greatest majority. Many of the people do not belong to any one religion, but do circulate from religion to religion. It would be hard to say if the reason is due to materialistic or spiritualistic values offered by any one religion.

It is estimated that there are anywhere from 10 to 15 Indian male "Spiritual Leaders" and two or three female "Spiritual Leaders" on the reservation. These men and women are mostly active during ceremonies held during the summer months, but are also active during any Indian celebration. The medicine given is mostly social and psychological, with hardly any chemical composition except Peyote, which is used in some of the ceremonies of the Native American Church.

Approximately 60 percent of the people speak Cheyenne and English. Thirty percent speak only English, knowing a few words in the Cheyenne language, and about ten percent speak Cheyenne, knowing a few words of English.

The Tribe is organized under its own constitution and by-laws adopted in 1936 and amended in 1960. The governing body is known as "The Tribal Council of the Northern Cheyenne" and consists of the President and 12 members chosen in the proportion of one member per 200 population and an additional member for each major fraction thereof. The principal source of Tribal income is from some 433,278 acres of trust land in Tribal ownership. Its program has been centered around the objective of bringing this land, as well as allotted land, into use by the Northern Cheyenne people. The Tribal Council administers Tribal funds.

Their assistance to tribal members covers a wide range of services, the most outstanding being Law and Order, financial enterprises and investments, education grants and scholarships, housing development, and construction of community buildings. Tribal interest and participation in Federal Government programs is increasing.

Tribal laws and ordinances are enforced by the Tribal police and court. A Special Officer employed by the Bureau of Indian Affairs assists in the investigation of Federal offenses. County and state courts are responsible for prosecuting offenses against non-Indians committed by non-Indians. Federal laws govern offenses committed by Indians against Indians or non-Indians, and offenses committed by non-Indians against Indians.

a. Mental Health Programs

The Mental Health Program staff appointed in the spring of 1973 consists of two women*. **Frances Dixon, R.N.**, whose training and background are similar to Ms. Towers, and who has had experience in the Denver Community Mental Health programs. **Ms. Dixon** is married to a Cheyenne Economic Development Advisor and enjoys considerably more interaction and rapport with Tribal Programs and individuals than most non-Indian Mental Health staff. Working closely with Ms. Dixon is Lazona Bailey, a Social Work Associate and member of the Northern Cheyenne Tribe.

The activities of this team are described in the Service Unit Profile as follows:

> The Mental Health Program includes daily individual, marital and/or family counseling and crisis intervention as a part of the mental health services. The program also includes consultation services to two schools, Lame Deer Public School and Busby School, with one afternoon a week devoted to the school. The consultation services provide opportunities for the teaching staff and administration to become involved in problem-solving situations with behavior problems in the classrooms. Informal classes and discussion sessions are being held once per week with the Busby dormitory personnel concerning subjects pertaining to mental health and concerning handling of behavior difficulties with students in the dormitory. Classes and discussion groups are conducted once a week with the Community Health Representatives, to familiarize them with aspects of mental health and to provide consultation concerning mental health problems.
>
> A small detoxification center was established through the joint efforts of IHS, BIA, Tribal Law and Order, and the Community Council on Alcoholism. This center provides a facility where alcoholics who express a desire for help, can receive medical assitance and counseling in quarters more favorable than the tribal jail.
>
> For the past two years, the Tribe has operated a shelter home for emergency care of neglected children. The BIA Social Welfare Department provides the social services and financial assistance, and IHS and the Community Health Workers become involved when necessary for illness and health supervision. This program could level itself to family counseling,

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*For earlier historical material on the evolution of consultation programs to the Northern Cheyenne, see pages 15-23.

> educational projects, and group therapy, but the opportunity has not been utilized very much."

In addition to the activities described above, **Frances Dixon** maintains close links with the Veterans Adminstration Hospital in Sheridan, especially the Alcoholism Unit, which utilizes her services on a regular schedule for inservice training of their staff both in mental health specialties and in facilitating their own learning to understand the Indian culture of their individual patients. She shares some of this activity with the IHS Mental Health staff at the neighboring Crow Reservation. It is interesting to note that this is a reversal of the traffic flow in 1963 when this V.A. Hospital provided the first regularly scheduled psychiatric consultation to the Billings Area.

Inpatient treatment is available at the Crow Agency Hospital which serves both Reservations and at V.A. and State Hospital facilities. This succint description does not begin to elaborate the many complexities and the variety of activities on this reservation. A better understanding of Mental Health Services can be gained from examining a tribal program which will expire as IHS establishes its own services.

b. Tribal Leaders Training Program, Lame Deer

There is considerable interagency activity flowing through the Lame Deer Health Center as a whole, and involving the Mental Health programs in particular. One program which is seldom mentioned in IHS reports, but which gives depth and substance to these activities is an NIMH funded program for developing tribal leadership skills. This program was initiated in 1969 by a team from the Sociology and Psychology Departments of the University of Montana in response to tribal interest in developing and administering their own programs. Initially the plan called for trainees to attend classroom instruction at Montana Southern University in Bozeman. Arthur MacDonald, Ph.D., a member of the Psychology Department and an enrolled Sioux, has provided the academic institutional liaison.

By 1972 the program was reorganized under a second grant, and Dr. MacDonald lived at Lame Deer where he and other faculty were able to provide the main body of training in a form coordinated with actual program development. This gave more control to the reservation and served as a stimulus for the development of academic resources and consultation within the setting of the Northern Cheyenne Reservation itself.

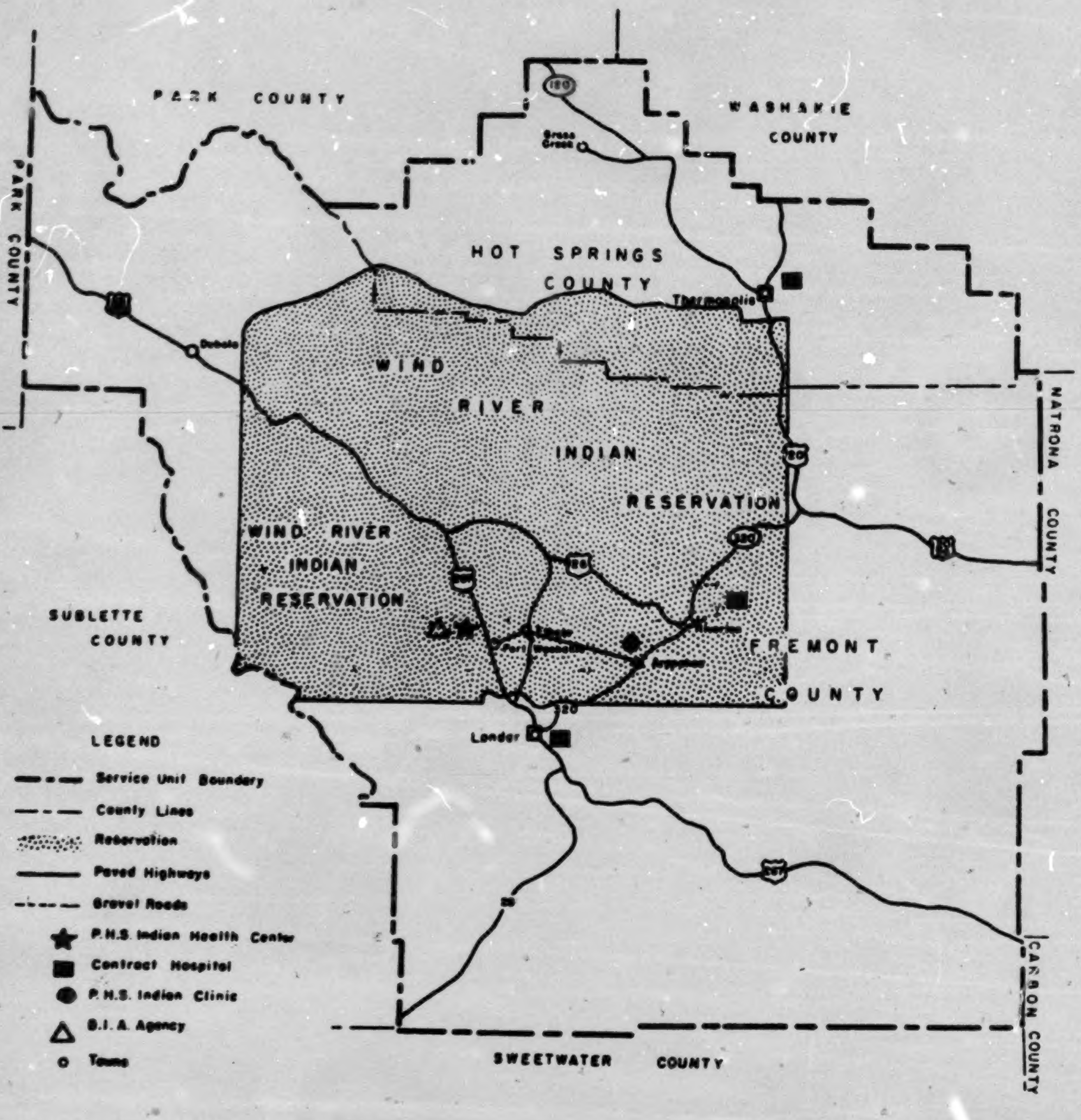
A nucleus of young tribal members were selected through nominations of the tribal units of government and local agencies. They have developed programs in legal, rehabilitation, school and economic spheres according to their individual interests. Among the projects in operation in 1973 were headstart and school dropout programs in Lame Deer and Busby. A crisis center was developed and scheduled for evening use most of the year. During tribal gatherings and festivals, ceremonials, and similar times of stress, the Crisis Center was manned on a twenty-four hour basis. In addition to developing skills in program development, proposal preparation, the tribal trainees have a deep knowledge of their tribal history, culture and political development, and are moving into age appropriate leadership roles.

This group has cooperated with IHS in funding the consultation services of Dr. Jerome Chadwick, a psychiatrist who was a consultant to Northern Cheyenne Reservation during his residency under the University of Colorado program. He is now in private practice in Denver. Dr. Chadwick seems to spend his time with tribal leaders rather than in the IHS clinic, but is in contact with the Mental Health staff.

Observations about the Northern Cheyenne Mental Health Program has the support of the Service Unit Director and will apparently do well as long as it balances its outreach for tribal contact and its consultative function to IHS staff. It presents an example of Mental Health activities well integrated into tribal mainstreams and very much a part of the life of the Northern Cheyenne. In many ways this pattern is the only one that might succeed in a tribe which has maintained its isolation from the mainstream of United States culture and development and which feels great threat from the surges of potential development of coal resources and the impact of large numbers of non-Indian personnel that such projects would bring both near and within the reservation. The utilization of tribal contracts which has been shown as a model in other Service Units should be a very helpful tool in developing additional services and strengthening programs in which the tribe has already shown interest and initiative.

8. **Wind River Reservation**

WIND RIVER SERVICE UNIT


PARK COUNTY
PARK COUNTY
WASHAKIE COUNTY
Grass Creek
HOT SPRINGS COUNTY
Thermopolis
Dubois
WIND RIVER INDIAN RESERVATION
WIND RIVER INDIAN RESERVATION
NATRONA COUNTY
SUBLETTE COUNTY
Fort Washakie
Arapahoe
Riverton
FREMONT COUNTY
Lander
120
26
20
287
CARBON COUNTY
SWEETWATER COUNTY
LEGEND
Service Unit Boundary
County Lines
Reservation
Paved Highways
Gravel Roads
P.H.S. Indian Health Center
Contract Hospital
P.H.S. Indian Clinic
B.I.A. Agency
Towns

1. GEOGRAPHY:

The Wind River Reservation is an area of about 3,500 square miles (2,268,000 acres) located within Fremont and Hot Springs Counties of west central Wyoming just east of the Continental Divide. The reservation is bordered roughly on the north by the Owl Creek Mountains which join the Rockies east to Wind River Canyon. The Bridger and Shoshone National Forests and the Wind River Mountains serve as border for the western segment. From these areas, streams flow south and east into the foothills and plains which constitute two-thirds of the reservation.

Climatic conditions in the area of the Wind River Reservation vary greatly due to the diversity of the land characteristics - mountainous terrain and plains. The annual mean temperature is 43.5°F. The mean temperature in January is 18°F. and in July 72°F. with the annual precipitation averaging between 15 and 20 inches. During a normal year, the sun shines 70% of the possible hours.

The Reservation was originally established by the Fort Bridger Treaty of July 2, 1863, and included 44,672,000 acres in Colorado, Utah, Idaho, and Wyoming. This area was reduced to 3,054,182 acres by the second Fort Bridger Treaty of July 3, 1868. The Brunot Agreement, dated September 26, 1872, ceded 710,642 acres from the southern border of the reservation to the United States. In 1957, the Shoshones received $433,013 for the land lost under this agreement. The McLaughlin Agreement of April 21, 1896, transferred 55,040 acres from the northeast corner of the reservation to the United States. The second McLaughlin Agreement, April 21, 1904, ceded 1,480,000 acres to the United States for homestead purposes and the Riverton Reclamation Withdrawal that covered 325,000 acres. In 1938, the Shoshones restored to the reservation the land alienated under this second McLaughlin Agreement. These lands, with the exception of the Riverton Reclamation Withdrawal, now belong to the reservation. Through these transactions the reservation has been gradually reduced to its present size.

The Reservation is now the home of two tribes, the Eastern Band of the Shoshone, and the Northern Band of the Arapahoe. The Shoshones are the original inhabitants of the Reservation, which was established solely for that purpose. In 1878, the Arapahoes were settled on the reservation when they were in need of a winter home. The Shoshones were awarded $4,453,000 in 1938 for the eastern half of the reservation occupied by the Arapahoes, and used part of this settlement to restore to the reservation the land mentioned above. The Shoshone Tribal Members principally occupy the western areas of the reservation including Fort Washakie, Crowheart-Burris, and the Dry Creek Ranch Area. The Arapahoe Tribe principally occupies the eastern segments of the reservation at Ethete and Arapahoe. Members of both tribes live in the Mill Creek-Boulder Flat Area. Descriptions of these areas are as follows:

Fort Washakie Area - The PHS Indian Health Center is located at Fort Washakie. This area continues east from the Health Center to the Chief Washakie Plunge.

The BIA and Tribal offices are also located at Fort Washakie. There are homes located at Fort Washakie and a number of ranches and farms located along South Fork, Trout Creek, North Fork and Sage Creek. The most distant home in this area is twenty miles from the Health Center.

Crowheart-Burris Area - This area covers approximately 18 square miles and lies 30 to 37 miles northwest of Fort Washakie on Highway 287 toward Dubois. A majority of the population in this area live in the area surrounding Burris and Crowheart and along the banks of the Big Wind River. The majority of the population in this area is engaged in ranching.

Dry Creek Ranch Area - The boundaries of the Dry Creek Ranch area reach from the Big Wind River north to the Owl Creek Mountains, west as far as Black Mountain, and east to Kinnear. This area consists of 410 square miles where there are approximately 30 families living on very large scattered ranches.

Ethete Area - The center of the Ethete community is located 17 miles north of Lander and 6 miles east of Fort Washakie. The majority of the homes in this area are located within a five-mile radius of the community center. There are a few Indian ranchers in this area, but most of the agriculture activity is by non-Indian farmers and ranchers.

Mill Creek-Boulder Flat Area - This area is located southeast of Fort Washakie, along U.S. Highway 287, approximately five miles north of the North Fork of the Popo Agie River which crosses Highway 287, 4.5 miles northwest of Lander. Families in this area live on scattered ranches or farms and have to travel from 5 to 20 miles to Fort Washakie for health services.

Arapahoe-St. Stephens Area - The Arapahoe-St. Stephens area of the reservation covers approximately 50 square miles and lies southwest of the town of Riverton, Wyoming, and 28 miles northeast of Fort Washakie. The major share of the homes are located in the vicinity of the Arapahoe Public School and along the banks of the Big Wind River and the Little Wind River. There is some farming and ranching in this area by Indians and non-Indians. Residents of this area generally use the Public Health Center at Arapahoe for health services.

Arapahoe Ranch - There are 13 homes located on Arapahoe Ranch property approximately 20 miles west of Thermopolis, Wyoming. These people work for the Arapahoe Ranch. They are approximately 80 miles distance from IHS health services at the Arapahoe Clinic.

Principal trade centers for residents of the reservation are Lander (pop. 7,125) and Riverton (pop. 7,995). Other larger cities in the area are Thermopolis (pop. 3,063) 80 miles to the northeast, Casper (pop. 39,361) 140 miles to the east, and Rock Springs (pop. 11,657) 150 miles to the southwest.

2. POPULATION:

The total Indian population served by the U.S. Public Health Service Indian Health Centers at Fort Washakie and Arapahoe is estimated at 4,004.

SERVICE UNIT POPULATION BY AGE GROUP AND SEX*
WIND RIVER SERVICE UNIT
FISCAL YEAR 1973

	TOTAL			FREMONT			HOT SPRINGS		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 5	538	264	274	525	254	271	13	10	3
5-14	1202	607	595	1159	583	576	43	24	19
15-24	763	394	369	744	384	360	19	10	9
25-34	483	252	231	469	245	224	14	7	7
35-44	374	179	195	361	174	187	13	5	8
45-54	284	151	133	274	146	128	10	5	5
55-64	178	84	94	169	81	88	9	3	6
65+	182	102	80	173	95	78	9	7	2
TOTAL	4004	2033	1971	3874	1962	1912	130	71	59

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* Population is based on 1970 Census and projected by Headquarters in memo dated November 23, 1971.

As of October 1, 1972, there were 2,968 enrolled Arapahoes and 2,134 enrolled Shoshones. More than 77 percent of the enrolled members of both tribes live on the reservation or elsewhere in Fremont or Hot Springs Counties. Refer to population table for age and sex distribution. As a whole, 62 percent of the population served by the Wind River Service Unit are in the age group Under One Year through 24 years of age; and, 43 percent of the total population are 14 years and under. Population percentage breakdowns are as follows:

Under 1 Year - 14 Years	43%
15 - 24 Years	19%
25 - 34 Years	12%
35 - 64 Years	21%
65 Years +	5%

Breakdown of total population by sex is 2,033 Male (51%) and 1,971 Female (49%). BIA estimates there are 814 families.

The Dependency Ratio for the Wind River Reservation (1971) was 4.78:1 as compared to the National Ratio of 1.70-1.80:1.

The Fertility Rate (1971) for the reservation was 148.5 live births per 1,000 women 15-44 years of age. This compares to the National Rate of 85.0/1,000.

The Rate of Natural Increase for the reservation (1971) was 22/1,000 population compared to the National Rate of 8.0/1,000 population.

These statistics are obviously significant in public health program planning and especially in the selection of program target groups.

From available PHS and BIA records, the following Table was prepared to show the approximate Indian population in each of the reservation areas and adjacent towns:

Area or Town	Population (Indian)
Crowheart-Burris	360
Dry Creek Ranch Area	159
Fort Washakie-Sage Creek	915
Ethete	927
Arapahoe-St.Stephens	1,006
Mill Creek-Boulder Flat	143
Arapahoe Ranch	69
Riverton	100
Dubois	6
Lander	216
Shoshoni	28
Thermopolis	75

6. EDUCATION FACILITIES AND LEVEL:

Head Start - There are three Head Start Centers on the reservation at St. Stephens, Ethete, and Fort Washakie, the total enrollment of all three centers is 75 children, ages 4 to 5 years.

Elementary Schools - There are three principal public elementary schools, Fort Washakie, Mill Creek, Arapahoe, and one parochial school, St. Stephens, (grades K-8) on the Reservation. Indian children comprise about 86 percent of the entire enrollment in these four schools.

Indian students also attend schools located within the Wind River School District at schools located at Crowheart (grades 1-5) and Pavillion (grades 1-8).

	Enrollment	
School	Indian	Total
Fort Washakie Public School	248	270
Mill Creek Public School	334	398
Arapahoe Public School	180	235
St.Stephens Parochial School	268	291
Crowheart Public School	19	25
Wind River Public School (Pavillion)	29	288
TOTALS	1,078	1,507

High Schools - Indian high school students attend public schools in Lander, Riverton, Morton, Wyoming Indian High School at Ethete (BIA Contract School) or BIA Boarding Schools. Approximate enrollments are as follows:

Lander Valley H.S. (grades 9-12)	113	934
Riverton H.S. (grades 10-12)	74	1,004
Wind River H.S. (grades 9-12)	25	136
Wyoming Indian H.S. (grades 9-12)	86	86
BIA Boarding Schools (grades 9-12)	100	100
TOTALS	398	2,260

In addition to the above, there are 15 Indian students attending the Riverton Junior High School (grades 7-9).

College and Vocational - Central Wyoming College is located in Riverton, Wyoming, and offers Associates of Arts and Science Degrees which are applicable to higher degrees at the University level. In addition to the two year college program, they also offer two year courses in radio and television engineering, secretarial science, graphic arts, business administration and management as well as computer science.

There are also Junior Colleges located at Casper, Worland, Sheridan, Torrington, Cheyenne and Rock Springs. The only four year college in the state is the University of Wyoming located at Laramie.

The BIA Education Specialist reports as of October 1972 there are 124 local Indian students attending various colleges and universities:

Central Wyoming College	19
Casper Junior College	7
University of Wyoming	12
Haskell Junior College (BIA)	24
Other	62

According to the 1971 Reservation Overall Economic Development Progress Report, during FY 1971, BIA Employment Assistance Branch had 28 active students enrolled in vocational courses, and the Construction Apprenticeship Program had 15 active participants during the summer and fall construction season. They also made 35 referrals to the Outreach Program and other agencies for training.

Educational Level of Reservation - The present median educational level of Indians in the reservation area is approximately 9.0 years; that of Fremont County was 12.1 years in 1960. This was reported in the 1971 Reservation Economic Development Progress Report.

Educational achievement for Indian residents of the reservation ranges from none to college graduates with post-graduate degrees. There are approximately 30 Wind River Indians with Baccelaureate Degrees or higher. The two Tribes should have over 200 college graduates to equal the national percentage.

7. TOTAL RESERVATION HOUSING:

According to HSM-41 Survey of October 1970, there were 676 private Indian households on the reservation with an average of five persons per home (this included 20 Low Rental Units and 20 Mutual Self Help Houses). Approximately 20 percent of these homes were below acceptable housing standards.

At the time of this survey, individually built homes comprised 82.4 percent of the homes surveyed. However, the recent acceleration of Federal housing programs is lowering this figure. Frame construction accounted for 57.4 percent of the Indian homes, with log homes (24.1 percent) and trailers (13.4 percent) accounting for sizeable percentages. The log homes are mostly older dwellings. A majority of the homes (63 percent) were four rooms or less; 27 percent of the homes had inadequate living space; and 31.5 percent of the homes had inadequate sleeping space.

Since the HSM-41 Survey was completed, a total of 60 new homes were built under the Low Rent and Turnkey Housing Programs. The Tribes have also submitted a request for 60 new home units for the elderly under the HIP Program.

These community programs have been very helpful in augmenting the activities of this Service Unit. However, it is very important that we keep each other informed regarding these programs so there will be no duplication of services.

11. SOCIAL-CULTURAL CHARACTERISTICS:

Except for the very elderly, almost all the Shoshones and Arapahoes speak, read, and write English. About fifty percent of the reservation population has a working knowledge of their respective native language.

The Shoshone language falls into the broad general group of Uto-Aztecan tongues, and the Arapahoe the Algonquian classification.

The first missionary to establish a mission at Wind River was the Reverend John Roberts, an Episcopalian from Wales who came here in 1883. Roberts Mission, built in 1885, still stands in the southeastern corner of Fort Washakie. Today, a majority of the Shoshones are Episcopal and the Arapahoes generally follow the Roman Catholic faith.

The Native American Church draws some Indians from both Tribes.

Each Tribe holds an annual ceremony known by the non-Indian as the Sun Dance. The literal Indian to English translation means "thirsty stand." The ritual, which begins in the evening or early morning, lasts 72 hours. The dancers eat no food or drink no water during this time. Those who partake do so for various reasons including healing of disease, thanksgiving, repentance and forgiveness of sins and spiritual resurrection. Usually no picture taking is allowed at these ceremonies.

The Shoshone and Arapahoe Tribes did not accept the provision of the Indian Reorganization Act of 1934 and thus are not chartered Tribes within the meaning of that Act. Each Tribe is currently governed by a Tribal Business Council of six members elected every two years. The respective Business Councils independently administer the affairs of each Tribe, and meet jointly as the Joint Tribal Business Council to carry out the business of common concern for the whole reservation. Capable individuals are often repeatedly elected to Council positions; for example, one individual was elected for eighteen consecutive terms. Currently, the Council members are all male, although competent females have been elected in the past.

In addition to the Business Councils, each Tribe also elects a Tribal Entertainment Committee which has the responsibility for social and religious activities including the annual Sundances, pow-wow's, the construction of lodges and the Indian holidays. The Business Council and the Entertainment Committee both are purely administrative. They carry out the policies of the General Councils of each Tribe which are composed of all enrolled members and meets as often as the need arises.

Indian medical practitioners are not easily identifiable, at least by the non-Indian population.

It is estimated that there are about ten practicing Medicine Men on the Wind River Reservation. The nature of treatment depends upon the individual Medicine Man's "gift". It is not uncommon for a patient to seek treatment from both the Medicine Man and the Indian Health Service physicians.

The Wind River Service Unit began meeting with the Joint Tribal Business Council in 1964. In July 1967, the Wind River Service Unit established a permanent liaison between the Wind River people and the Public Health Service staff through the Service Unit Director. An attempt was made to establish a health committee composed of interested Indian people who would meet with the Service Unit Director on a regular basis. The Joint Tribal Business Council, however, felt that such a committee interposed an unnecessary complication in accomplishing any work, because such a committee would require authorization of its actions through the Joint Tribal Council. It was their desire that the entire Joint Tribal Council meet with the Service Unit Director on a regularly scheduled basis. This has been accomplished and has proved quite satisfactory.

Meetings are held with the Service Unit Director in attendance every Wednesday afternoon in the Tribal Office Building. The Joint Tribal Council has allocated this time for discussion of health care and as much time as necessary is utilized, usually from one half to one hour. At this time, health care programs and proposals are aired and discussed, and difficulties with the clinics, staff and programs are generally resolved. Where in-depth discussion and evaluation is required, meetings are scheduled between Service Unit staff and Tribal Council Health Representatives, two from each Tribe.

Ultimately, the Service Unit Planning Guide should reflect the degree of "tribal involvement." Toward this goal, we at Wind River have expressly invited all interested Indian people to participate in the preliminary discussions of program planning. Participation at inception has been only fair, but hopefully, given the time and implements to identify health care programs, the Indian people will structure the Guide to reflect their priorities for deliverance of health care. At present, two Tribal Council members from each Tribe and the CHR supervisor are members of the Service Unit Planning Committee along with Indian Health Service staff members, Indian and Non-Indian.

In order to foster better communication and utilize local resource people, in our effort to reach our Indian patients, monthly in-service training and information sessions have been organized to include Joint Tribal Council members, CHR's and IHS staff. Hopefully, a mutual intercourse of ideas and facts will better help us understand each other.

Additional examples of tribal involvement must include the CHR Program, Maternal Health Program, the sponsorship of Head Start Programs and a Day Training Center for mentally and physically handicapped. At the suggestion of tribal members, a playroom was installed at the Fort Washakie Clinic, television sets were installed in the waiting rooms of both clinics at the Tribes' expense. Currently, the Service Unit stocks with medical supplies a small trailer purchased by the Shoshone and Arapahoe Tribes. The trailer is present at all summer celebrations and emergencies are seen at the trailer by either the CHR's or the Indian Health physicians.

a. Mental Health Program Activities

Tribal involvement is a term easily misused and a concept which often spawns token response. It is our duty to see that the Indian becomes integrally involved in health care management and planning so that he may soon assume the real leadership of these programs and establish his own set of goals and priorities."

These views, expressed by the SUD at Wind River, indicate more than ordinary awareness of the undercurrents of emotion that affect all federal program development. This impression is borne out by the comment made by Dr. Gustafson, Area Chief of Mental Health, in December 1971, following his initial visit to Fort Washakie.

> The contract mental health staff at Wind River, namely Dr. Miracle and Dr. Stapleton, have been meeting regularly with the medical doctors to discuss current problems in medical care. I attended one of these meetings and found it very interesting and productive. The subject of this particular meeting was how to understand and deal with hostility toward one's self as a medical doctor. The understanding of this kind of hostility is probably useful to our medical physicians at every service unit. Part of the discussion included consideration of political, cultural, and family sources of hostility. The political includes the need of tribal groups to find common enemies in order to cement their own solidarity; the cultural includes the fact that tribal members themselves are subjected to these kinds of attack; and the family source includes the problem of guilt for ill feelings towards sick family members which can be eliminated by making the doctor responsible for matters that go wrong with the sick family member.

In addition to the two professionals (Dr. Brian Miracle, Ph.D., and Dr. Thomas Stapleton, M.D.), the Mental Health Staff at Wind River also includes Darwin St. Clair, a Mental Health counselor at the paraprofessional level. Mr. St. Clair's monthly report for September 1972 is short and direct:

> Month of September, 1972:
>
> Number of patients counseled by the Mental Health staff:

Fort Washakie and Ethete	14 patients
Arapahoe	23 patients

Other agencies or departments Mental Health Staff visited:

Bishop Randall Hospital, Lander, WY
Fremont County Memorial Hospital, Riverton, WY
County Sheriffs Office, Lander, WY
Vocational Rehabilitation Center, State Training School, Lander, WY
Elementary Schools:
Arapahoe School
Fort Washakie School
Mill Creek School
Lander Valley High School, Lander, WY
Datal Center, Riverton, WY
City Jail, Lander, WY
County Attorney's Office, Lander, WY
Advisory Meeting = St. Michael's Youth Center, Ethete, WY

There were no suicidal attempts reported this month."

The expansion of services, as well as the development of Mr. St.Clair's confidence and skill, is reflected in his report fifteen months later, dated January 1973, and summarizes the activities of the preceding quarter.

> Clinic and Hospital Activities:
>
> This quarter 52 patients were counseled during Mental Health Clinics at the Fort Washakie and Arapahoe Clinics (27 at Fort Washakie and 25 at Arapahoe).
>
> Eight hospital inpatients (Bishop Randall Hospital) were followed this quarter. Hospital patients are visited daily by Dr. Miracle and every other day by the Mental Health Worker. The Medical Social Worker also visits all Indian inpatients twice a week. Two of the patients were hospitalized because of depression, one patient for overdose of unknown drug, and five patients were hospitalized for alcoholism and DT's. One of these patients expired and one was transferred to ITATC at Sheridan after detoxification.
>
> One patient was also followed at the Fremont County Memorial Hospital for alcoholism. If possible, Dr. Miracle's patients are usually transferred to Bishop Randall Hospital where he makes routine daily visits and is always close by in case of emergencies. Severe cases are not transferred such as in this case and special trips are made to the Riverton Hospital by Dr. Miracle and the Mental Health Worker.

Special Services:

Our communications and relationship with the State Vocational Rehab people has been very good. They referred five Indian patients who had been referred to them to us this quarter for psychological evaluation testing. They are always willing to work with us in planning for our patients that are eligible for their services.

Both Dr. Miracle and I are members of the St. Michael's Youth Center Advisory Board at Ethete. We meet monthly as a board and we also do individual counseling of students.

Dr. Miracle and I appeared in District Court three times this quarter in regards to patient Involuntary Commitments to the State Hospital in Evanston. Involuntary Commitment papers are signed by a patient's relative. There has been some misunderstanding by residents who feel IHS should commit patients who will not sign voluntary commitment papers. Our policy has been to help patients and their relatives as much as possible in voluntary and involuntary commitments to the state hospital. This includes getting doctor's reports, making appointments with county attorney, getting papers notarized and providing transportation to court.

At least once a month, visits are made to Fremont Manor Nursing Home in Riverton to visit with Indian residents and personnel of the home and help with any problems they may have.

Regular visits are made to the tribal, city and county jails. There has been very good cooperation from all law enforcement agencies, and we in turn help them as much as possible with people they refer to us.

Suicides:

During this quarter there were three suicide attempts reported (three overdoses) and two completed suicides (both by gunshot). None of these patients were seen by or referred to Mental Health personnel prior to their attempt.

Follow-up visits are made to all known patients who have attempted suicide.

School Program:

Meetings were held with the officials of the three public elementary schools on the reservation. They were informed about the mental health services we have available. The Mental Health Worker makes weekly visits to the schools to meet with individual teachers and to help with any problems they refer.

Mill Creek School has requested some special help in the observation and testing of some of the children in their special education program. This is the first time this school has really used our mental health services.

With improved communications, the other schools will probably use our services more also.

Other Activities:

A trip was made to the State Hospital and State Prison during December by Dr. Miracle and I. An airplane was chartered for this trip. Others making the trip included Medical Social Worker and two State Vocational Rehab staff members.

We visited the State Hospital at Evanston first. We visited with the officials of the hospital and three of the patients. one 26 year old man we had helped get into the hospital's alcoholism program kept thanking us for helping him. This made us feel very good.

From Evanston, we flew to the state prison in Rawlins. A meeting was arranged for us and we were able to visit with 12 Indian prisoners (5 were from Wind River). We just listened to them. Overall, I felt the trip was very worthwhile.

A one day trip was made to Thermopolis (Dr. Miracle, Vocational Rehab, Mental Health Worker) to visit a patient and ended up bringing her back to Bishop Randall Hospital for treatment and therapy.

The last week of November, the Mental Health Worker and a local school teacher attended a two day workshop in Billings on School Consultation.

Progress Relating to Emphasis Plans and/or Problem List:

A. Disciplinary Problems

   2. Suicide Attempts
   Plans are now being made to visit the local radio stations to work out arrangements for spot announcements and information programs regarding mental health services available to local residents.

C. Interagency Problems

   2. Alcohol Abuse

   To date, no progress has been made. This will be emphasized this next quarter. There have been problems in getting everyone together for a meeting especially during the holidays.

There is also a Medical Social Worker on the Wind River Reservation, John T. Cross. The interrelationships of his office with the Mental Health program are indicated in the description of his activities quoted below from the 1972 Service Unit Profile.

> Medical Social Worker, John T. Cross - There are seven major areas of action for the Medical Social Worker on the Wind River Reservation. Approximately 50 percent of working time is spent in medical-psychiatric social services which includes a regularly scheduled hospital visitation program to the Lander and Riverton Hospitals. Positive aspects of this program includes the early interception and treatment of social and emotional problems resulting from injury or illness, early referrals to resource agencies such as Public Welfare, Vocational Rehabilitation, etc. The Medical Social Worker also helps staff the weekly Mental Health Clinics at Arapahoe and Fort Washakie.
>
> About 20 percent of Medical Social Service time is spent in community development activities such as day care, nursing home, alcoholism, etc. Medical Social Services took a survey to determine the need for a day care center for working mothers, and is presently assisting local groups in locating resources to establish such a facility. The Medical Social Worker also serves as a consultant to the Day Training Center at Ethete, St. Michael's Children's Home, Alcoholism Rehabilitation and Employment Group who have been trying to establish a Half-Way House on the reservation, and the CHR's.
>
> The remaining 30 percent of Medical Social Service time is spent in the remaining areas such as staff development, orientation, consultation, cooperative efforts with other disciplines and agencies, referrals, service expansion, etc.

Other Mental Health resources and Agencies available to the Wind River Reservation are described in the Service Unit Profile as follows:

Mentally Retarded and Epileptic

> The Wyoming State Training School which is controlled by the State Board of Charities and Reform accepts children under the age of 16 on a voluntary commitment or by Court action at any age. Eligibility requires one year residence in Wyoming and medical and psychological evidence substantiating that the person has a seizure disorder or is mentally retarded. Medical services and educational programs geared to maximum utilization of the mentally retarded person's capacity is the goal of the institution. The school is residential and capacity is about 75 residents.

> Children over 12 Years and Adults - The Wyoming State Hospital, which is under the State Board of Charities and Reform, provides medical, psychiatric and rehabilitation services to those diagnosed as "mentally ill or suffering from the disease of alcoholism". One year's residence in the State is necessary and admission may be voluntary or by court commitment. A "means test" is required.
>
> The State Hospital has a 16-week comprehensive rehabilitation program for alcoholics. Program includes education, group therapy, A.A. and vocational rehabilitation services.
>
> Veterans - The U. S. Veterans' Administration Hospital at Sheridan, Wyoming, provides an Alcoholic Rehabilitation Program to eligible veterans. The program consists of 90 hours of educational instruction on the disease concept of alcoholism through the media of audio-visual aids and lectures. There are also 60 hours of group psychotherapy provided and 24 hours of indoctrination into Alcoholics Anonymous.
>
> Inter-Tribal Alcoholism Treatment Center - The Inter-Tribal Alcoholism Treatment Program is located on the grounds of the Veterans Administration Hospital, Sheridan, Wyoming. They occupy buildings 3 and 24. This is a unique program in that it is staffed entirely by Indian personnel and they have, to date, had a high success rate as compared with other facilities.
>
> Fremont County Counseling Service - This facility is located in Lander, Wyoming. Wind River Service Unit contracts through this facility for the Psychologist who spends three days a week at our clinics.

The most recent summary of Mental Health Programs is also brief and direct. It is quoted in full below from the Service Unit Profile:

> Mental Health Services - The Mental Health staff consists of a Mental Health Worker, Contract Clinical Psychologist, and Contract Psychiatrist. The Clinical Director supervises the Mental Health Program. The Mental Health Worker assists the Clinical Psychologist and Psychiatrist in consultations and therapy; he also provides consultation to the physicians and other personnel regarding Mental Health activities at Fort Washakie and Arapahoe Clinics. The Mental Health Worker works closely with the following agencies:
>
> BIA - Social Services, Juvenile Office, Law and Order
> Tribal - Courts, ARE's, CHR's
> County - Social Services & Welfare, Courts, Sheriff's Office
> State - Vocational Rehabilitation, Hospital
> Schools - Public and Private on or near reservation
> Hospitals - County, State and V.A.
> ITATC - at Sheridan, Wyoming.

The Contract Clinical Psychologist, Brian Miracle, Ph.D., is available three days a week for consultation and therapy. He provides services in: Marriage Counseling, Testing, General Psychological Counseling, Alcoholism Treatment, Emergency Crisis and Home visits.

The Contract Psychiatrist, Thomas Stapleton, M.D., is available twice monthly for consultation and therapy. Normally he sees referrals of special or severe problems and provides consultation to the Mental Health staff as well as physicians and other professionals.

Mental Health Clinics are held weekly at both clinics - Thursdays at Arapahoe and Fridays at Fort Washakie. During FY 1972, 211 patient visits were made to the Fort Washakie Mental Health Clinic, and 138 visits were made to the Arapahoe Mental Health Clinic. These clinics are staffed by the Mental Health Worker, the Medical Social Worker, and the Contract Clinical Psychologist.

A special file on patients who have attempted suicide is maintained in a confidential file, and patient's general medical folder is flagged to alert the physician at the time such patient visits the clinic.

9. Intermountain School

The same problems that seem to plague all attempts by IHS to introduce Mental Health programs into BIA Boarding Schools seem to have developed over the years at Intermountain Indian School. When the BIA School staff shares the common philosophy of fostering healthy growth and development as the Mental Health staff, then both treatment of disturbed youngsters and consultation and preventative programs seem to be possible. It does not happen when there are marked differences in philosophy, sense of the purpose of the school, or in degrees of security in working with cross cultural settings, and even in degrees of comfort in adapting and changing techniques and administrative details. In both systems, BIA and IHS, the relatively high **turnover of staff at all levels makes continuity of program development impossible without these kinds of agreement at the levels of the bureaucracies involved.**

When Dr. Gustafson visited Intermountain School in September of 1972, the program problems caused him to reflect upon the boarding schools as sources of later mental health problems. His comments are quoted from his narrative report:

> AREA PROBLEMS
>
> Responsibility and Schools: I was struck on my visit to the Intermountain School, in talking with Dr. Wayne there, with how much the school regulates the life of the students, keeps track of all their comings and goings, and in general, takes responsibility over these students, rather than allowing students to be responsible for themselves.
>
> I later talked with Art McDonald (University of Montana Psychologist who has organized a Tribal leaders educational project at Lame Deer) about this state of affairs. He agreed that this typical BIA school operation did in fact tend to totally externalize responsibility from individual Indian students with results that students were often lost to themselves and others when graduated from school. I think we should look very carefully at this destructive process in all the schools that we consult with. Of course, the emphasis of such a school consultation would have to be on the way the classroom is run, rather than what any given individual problem student is doing.

This same monthly Narrative describes action taken to revive the Mental Health program at Intermountain School:

> New Intermountain School Programs: Dr. Dennis Wayne and Mr. Brent Price, Social Worker, of our staff at Intermountain have taken some initiatives to renew the program at Intermountain. The two major changes are, first, to assign nurses to work with individual students on the inpatient unit, and two, to have a joint PHS and BIA staffing on all "problem students" whom the school wants to send into the problem dorm or into inpatient unit. The latter development gives Dr. Wayne and Mr. Price an excellent chance to consult with the school about pressures on students that are forcing them into these special situations.

The monthly narrative received from Dr. Wayne at the end of October indicates that two paraprofessionals had been added to the Mental Health staff and that arrangements to utilize the services of Dr. Carl Keener, Denver, as a consultant were being initiated. His report seems worth reporting in full because it describes very typical problems and strategies often employed to solve them in the boarding school context.

Accomplishments:

1. Staff- Mr. Robert Holly permanent Social Work Associate on duty. Mr. Kevin John on the job in a temporary position. Re-evaluation of applicants for this other permanent position will be made in near future.

2. Enhanced staff responsibility - Each member of the Mental Health Team is viewed and has authority to be a therapist and make decisions regarding their patient. Hopefully, this will lead to more responsible involvement with students and in turn, the students' acceptance of more responsibility.

3. Interagency communication - Using the vehicle of "staffing" on so-called problem students to relate to BIA staff and inculcate "mental health concepts". This vehicle also acts to make staff more responsible since it is more difficult to make unilateral decisions, i.e.: expelling.

4. Approval Observation Room - This room provides an area to handle uncontrollable students. In the future, my real concern is for political policy to influence its use/ see proliferation of such rooms elsewhere.

Plans:

1. Mr. Brent Price, Social Worker, plans to attend Group Relations Conference in early November.

2. Both Mr. Price and myself plan to take part in school consultation seminar in Billings in late November.

3. Visit of Dr. Carl Keener in early November to provide consultation to Mental Health Unit.

4. Formulate and discuss policy and criteria for admission to Inpatient Mental Health Unit with School Superintendent and his representatives.

Problems:

1. Issue of future of Health Center and its effect on staff morale.

2. To do work in a setting where task of school and Mental Health program are at variance.

The difficulties are compounded in the Billings Area since the students at Intermountain are now all Navajo. They come from the Southwest, a long distance away from Montana or Wyoming, and there is no easy way to develop an integration of the remedial, treatment, or preventative programs with the homes, schools and agencies responsible for arranging for the students to attend Intermountain, or for follow-up services after a student leaves. This makes the program at Intermountain seem even more detached from all other elements of the Area than the isolation ordinarily generated by geographic distance. In addition, the Billings Area has no other responsibilities or activities in the state of Utah.

Initially these problems were resolved by contracting for local psychiatric consultation from Salt Lake City. However, early in 1973, after some negotiation, Dr. Carl Keener undertook the consultation role from Denver, and a serious effort to involve the staff of the Health Center in seeing the Mental Health implications of their roles with students has been made. Some work with BIA School staff and IHS Service Unit staffs is being attempted. What level of coordination with the Navajo Area and Tribal agencies is being accomplished at this time is unclear.

10. Detoxification Programs

Starting in 1972 with the Flathead Reservation, the Billings Area began recognizing a gap in services for alcoholism rehabilitation that was not easily met by other sources of funding. Detoxification services require medical supervision which seems rightfully to be a service of IHS, but most physicians and Service Units were unprepared and understaffed for this particular type of service. While it was true that IHS facilities were frequently called upon informally, usually in the treatment of traumatic injuries incurred during 'drunken brawls' or acute episodes of illness exacerbated by alcoholism, the physicians tended to feel that treatment of alcoholism was separate from, or even a deterrent to the delivery of their specialized health services.

However, the use of the few state facilities established for detoxification usually involved lengthy travel, separating the involved patient from the family, the counseling resources, and the local situations which could most effectively be coordinated in a total rehabilitation program. Ms. Tower began exploring the possibility of IHS contracting through its mental health programs for the specific provision of these services by the local Service Units. This expanded the role of many of the Mental Health professional staff, who acted as consultants to the local alcoholism counseling programs established under BIA, NIAAA, LEAA, and other funding sources. By September 1974 most of the Billings Service Units had established these services on a contract basis, and by May of 1975 the results could be summarized. The report of the Director, Billings Area IHS summarizing these programs and their anticipated costs for FY 76 is quoted in full below since the organization and operations of this detoxification program is unique as an Area-wide activity.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MAY 16 1975

Director, Indian Health Service
Rockville, Maryland

Reply to: A/MH

Director
Billings Area IHS

Status of Detox Programs with Estimate of Increased Costs for F.Y. 1976

Alcoholism has been identified as the major unmet Health need in the Billings Area both by the Indian Health Board and the Indian Health Service staff. In order to begin to meet this need IHS negotiated contracts for detoxification services on all eight reservations in F.Y. 1975. Each program is described in this report according to the amount of the contract, services being offered, available statistics, accomplishments, problems and additional funding needs. Funding from the State, BIA and tribes has been generated by the IHS-Detox seed money and is identified in this report. Seven of the eight units have less than the minimum staffing required to operate a 24 hour a day, 7 days a week program. This request for additional funds is based on the amount needed to bring the units up to minimum staffing levels.

Admission of clients to the Detox Units began in September at most service units. The total number of admissions in the period September, 1974 through April, 1975 is 1,407. There have been about 4,220 client days in the eight month period. The total amount of the detox contracts was $287,760 in F.Y. 1975. The cost per client day has been about $45.00 according to the figures presently available. Additional statistical information regarding repeat admissions, age, employment and drinking patterns will be available in June, 1975 when the year end reports are submitted. Statistical information will be more detailed in F.Y. 1976. Copies of the two reporting forms to be used in F.Y. 1976 are attached. (See attachments 1 and 2)

In general, initial problems were related to program organization and relationships between the alcoholism staff and other resource agencies. During the process of negotiating the contracts a closer working relationship developed between the alcoholism staff and IHS physicians, IHS Mental Health staff and service unit directors. The necessity for performing the services such as follow up described in the contract brought other tribal programs into a closer working relationship with the alcoholism staff.

There have also been other important outcomes. One outcome has been the increased number of clients being treated in an alcoholism program rather than the jail or Emergency Room. Another important outcome has been the change in attitude of many tribal and IHS personnel. Initially there was considerable negativism expressed about

a) spending so much money in an area where the outcome was uncertain
b) the ineffectiveness of the existing alcoholism programs
c) the futility of trying to "do anything about alcoholism"
d) the futility of working with IHS and the untrustworthiness of said agency.

These attitudes changed as the programs demonstrated their effectiveness and as IHS demonstrated their support. A great deal of interest and pride in the program has developed at the local level.

We are optimistic about the program and expect to demonstrate a gradual but definite improvement in the picture of alcoholism as a result.

Detoxification Contracts and Services by Reservation

Blackfeet: Amount $34,860. The Blackfeet Health Board is incorporated and serves as the contractor for the Detox Unit. Three Detox counselors have been hired as provided in the contract. The Program Director is responsible for supervision. The counselors attended a training workshop in Lame Deer the last week in July. They have also had a Detox Training workshop utilizing local resources in Browning. On August 15 the three-bed Unit was officially opened and two of the beds were filled the same day. Since that time the three Detox beds have been full and additional clients have been admitted to the Halfway House. The total number of clients admitted between August 15 - April 30 is 331. Eighty of those admissions were repeaters. The number of clients admitted far exceeds expectations. This program staff was initially demoralized and viewed as ineffective by the community and Indian Health Service staff. Physician and community attitudes have shifted dramatically since the opening of the detox unit. The alcoholism staff have worked very hard to develop the program. An additional factor has been the excellent work of an IHS mental health consultant who has worked nearly full time with the staff. Policies and procedures have been developed. Group therapy, individual counseling, help in finding jobs, Halfway House facility, A.A. program and a court referral system are part of the program. Working relationships between the program staff and other agencies have improved significantly. The staff is continuing to work out some kinks that remain in their organizational structure. The main problem in this program however, is that it is under budgeted for the number of clients being treated.

Crow: Amount $35,840. The contract for the Detox Unit is with the tribe. The Unit is located in the Rehabilitation Complex which is planned eventually to include eleven buildings. The Detox Unit is in a facility originally planned for juvenile detention. There have been ups and downs with this program, but the program is running smoothly now and appears to be developing into one of the more successful contracts. The first proposal submitted by one faction of the tribe along with the service unit personnel was brought under heavy fire by other tribal groups and by MICADA because of the influence of IHS staff in developing the proposal and the presence of IHS staff on the Board. The Area Director took the position that no IHS staff should be an active member of the Board. Everyone was concerned about "keeping it out of politics," which, on the Crow Reservation, is impossible. So, we began to work on the problems, politics and all, to develop a second proposal. The second proposal, developed by the Rehab staff served as the basis for the contract, but very soon fell prey to "politics." The Rehab staff withdrew their support and the project began to flounder. None of the ten programs involved could agree on an organizational structure. Selection of personnel became a political issue which was an added problem. Two meetings were held with the Chairman and the Director of the programs most closely involved; agreements were made, but the program remained at a standstill--no beds, no blankets, no patients. MICADA staff provided some consultation during this time also. Finally, in October the alcoholism staff and the Chairman were told that we could not pay for services we were not getting and that until services reached an acceptable level there would be no more payment. The acceptable level of service outlined by IHS was agreed to by the staff as being fair, but they weren't sure they could meet the conditions. Immediately after this meeting a second meeting was called by the Chairman; every director of every related program was at the meeting, and in a day long marathon the role and responsibility of each program in relation to the Detox program was negotiated and finally settled. Within one week the program was fully operational, 6 clients had been admitted and the Detox Unit was in business. A great deal of credit goes to all the people who were involved in this very difficult situation for resolving their differences in a manner which permitted the program to realize its potential. From November, 1974 to April 30, 1975 there were 303 admissions.

Fort Belknap: Amount $30,000. The contract for the Detox Unit is with the tribe. The Unit is located in a room in the PHS Hospital and is staffed by a supervisor, two detox counselors and two counselors from the existing NIAAA program. There were serious problems implementing this program. Communication between the alcoholism staff and service unit staff was sporadic so problems did not get discussed and settled. There was poor selection of staff at the outset so there have been three sets of detox staff.

Ft. Belknap - cont'd. In October, a meeting was held with the staff to discuss the difficulties. Members of the MICADA staff were called on as co-consultants with the Indian Health Service Mental Health staff, but problems continued. In November, a letter was written to the Director and the Chairman describing the problems and the efforts to resolve them. The letter also stated that no further payment would be made until services reached an acceptable level. The effect of this meeting was to get the Chairman and Council concerned and interested and a serious effort to provide the services was made. Currently the striking feature of this program is the commitment of the tribal chairman. He has taken a personal hand in securing additional funding and in developing a rehabilitation component. LEAAA funds were utilized to obtain a new building for the Detox-Halfway House Program and for remodeling another building for use by the follow-up counselors. To date there have been 66 admissions to the program.

Flathead: Amount $44,560. This is the third year of this contract with the tribe. The program was started in June, 1972 with special alcoholism money received by the Mental Health program. This program served as the pilot project and model for our present detox contracts. The original concept was to have a Detox-Crisis Center which would serve as a crisis intervention-suicide prevention resource as well as a detoxification unit. To that end, intensive training in alcoholism and crisis intervention counseling was provided. However, the unit is not viewed by the community at large as a crisis intervention center in spite of diligent efforts on the part of the staff to promote many suicide calls; they do get many calls, at all hours, from clients and their families. So, for a segment of the population it seems to be a crisis resource.

This Unit is located in a private hospital in contrast to most of the other programs. We have found that there are fewer medical emergencies than we anticipated. Construction of a comprehensive facility will begin summer of 1975. Having the Unit in the hospital had the initial advantage of helping change the attitudes of the physicians, nurses and the Board of Directors of the hospital toward alcoholism. The hospital director was also very helpful in getting newspaper articles printed, speaking at various clubs about the program and in smoothing over some of the negative reactions of the nurses.

The Detox staff consists of a supervisor and five counselors. The staff is excellent and worked very patiently to overcome people's initial negativism about the program. Staff turnover has been very low in this program which has contributed to its success.

Flathead - cont'd. The Flathead alcoholism program has developed, in the last two years, into a model comprehensive community alcoholism program. Services offered now include:

a) Community Information Center
b) Detox Unit
c) Halfway House
d) Education program for school-age children
e) Drug Abuse program
f) Drinking Driver program
g) Follow up

    1. Job Placement
    2. Long-term Counseling
    3. Family Counseling
    4. Coordination with Resource Agencies
    5. Referral to long-term treatment facilities (17% of clients - 83% treated within the community).

There is a strong alcoholism program board which has developed in the last two years which helps keep political issues at a minimum. The staff has expanded as have the services. The organizational chart of this program is attached.

The statistics also reflect the increased effectiveness of the program as a whole. In F.Y. 1973 there were 102 admissions. In F.Y. 1974 there were 120 admitted and in F.Y. 1975 there will be 160 admissions. In F.Y. 1973, 30% of the clients were referred to Galen (the State Hospital Treatment Center). In F.Y. 1975 less than 10% were referred to Galen. Follow-up services have increased dramatically. Until last month, two people were seeing 100 clients per month. Two more counselors have now been hired to do follow-up.

This project staff has demonstrated what "can be done" about alcoholism. Community attitudes have changed; there is more awareness of the complexity of alcoholism; community interest in alcohol education is much higher; many more people are being treated for alcoholism. In F.Y. 1973, the Flathead Detox Unit admitted as many patients as all the other reservations combined.

Prior to the Detox Unit, jail was the primary resource for detoxification.

Fort Washakie: Amount $10,000. The contractor is the Joint Business Council of the Shoshone and Arapahoe Tribes. The services of this contract includes detoxification services and residential care. The staff of this program in conjunction with the Service Unit Director and Mental Health Consultant have been quite successful in obtaining State (Wyoming) support for this program. Counseling services, A.A. program, a court referral system and group therapy are available. The Community Mental Health Center from Lander also provides service in the alcoholism program so a variety of state and federal resources have been brought together in this program. To the present time, 88 clients have been treated. One program gap is in the area of job placement and working with employers. The staff is beginning to try to meet this need.

Fort Peck: Amount $70,000. The tribe is the contractor for the Detox Unit. Eight beds are available. The supervisor and five counselors have been hired. However, there has been a turnover of two people in the supervisor position and a third person is currently hired. Another factor which has adversely affected the program was the slowness in getting a tribal industry moved out of the building intended for the Detox Unit. The Council finally took action when the Alcoholism Director told them they were in danger of being in non-compliance with the contract. There is a Detox Board which meets once a week to discuss problems and formulate policies. A total of 174 clients have been admitted between September 1 and April 30.

Our working relationship with the staff of this program has been very good in spite of some differences of opinion regarding program philosophy.

This program was initially funded at a higher level than others to meet other program needs. We plan to decrease the budget in F.Y. 1976 to 55,000.

Northern Cheyenne: Amount $32,500. The Northern Cheyenne Council on Alcoholism and Drug Abuse is incorporated and serves as the contractor for the Detox Unit. The Detox Unit is located in part of the Halfway House and is staffed by three counselors. The Alcoholism Director acts as the supervisor. Services are available 24 hours a day. This staff hired their Detox personnel in May, organized the first training workshop and began admitting patients in June. To date 185 clients have been seen. Cooperation between the Alcoholism Program staff and IHS staff has been good. In the early stages of contract development there was considerable distrust of IHS expressed by the Alcoholism Director. The fear of the staff was that IHS would "take over," "impose white middle class values," and "impose a lot of bureaucracy." Gradually these statements faded from the discussions as the feared imposition failed to materialize. The Director of this program feels that the willingness of IHS to undertake the detox contracts was a real turning point and improved many people's opinion about the sincerity of the IHS staff.

Rocky Boy's: Amount $30,000. The Chippewa Cree Health Board is incorporated and serves as the contractor for the Detox Unit. The contract for services on this reservation is a little different due to the difference in need. The need was for two counselors to work with the existing staff and other resources (Halfway House in Havre and the hospital in Havre) to provide a drop-in center, counseling to the client being detoxified, liaison services between facilities in Havre and those on the reservation, non-medical treatment of mild and moderate withdrawal symptoms, development of an A.A. program as a supportive service for all detoxification clients and development of bilingual education material to be used during follow-up. Total clients seen has been 90 which is three times the number seen in any previous year. Recently they have added a 24 hour 7 day a week capability to the reservation program making additional staffing a necessity. The goals of developing bilingual educational material and developing an A.A. program have been met and the program is going quite well.

In F.Y. 1976 the Bureau of Indian Affairs has agreed to meet the subsistence costs of the Detox-Halfway House program. The IHS contract will cover salaries, benefits, travel, training and equipment costs of the detox units.

J. R. Smith

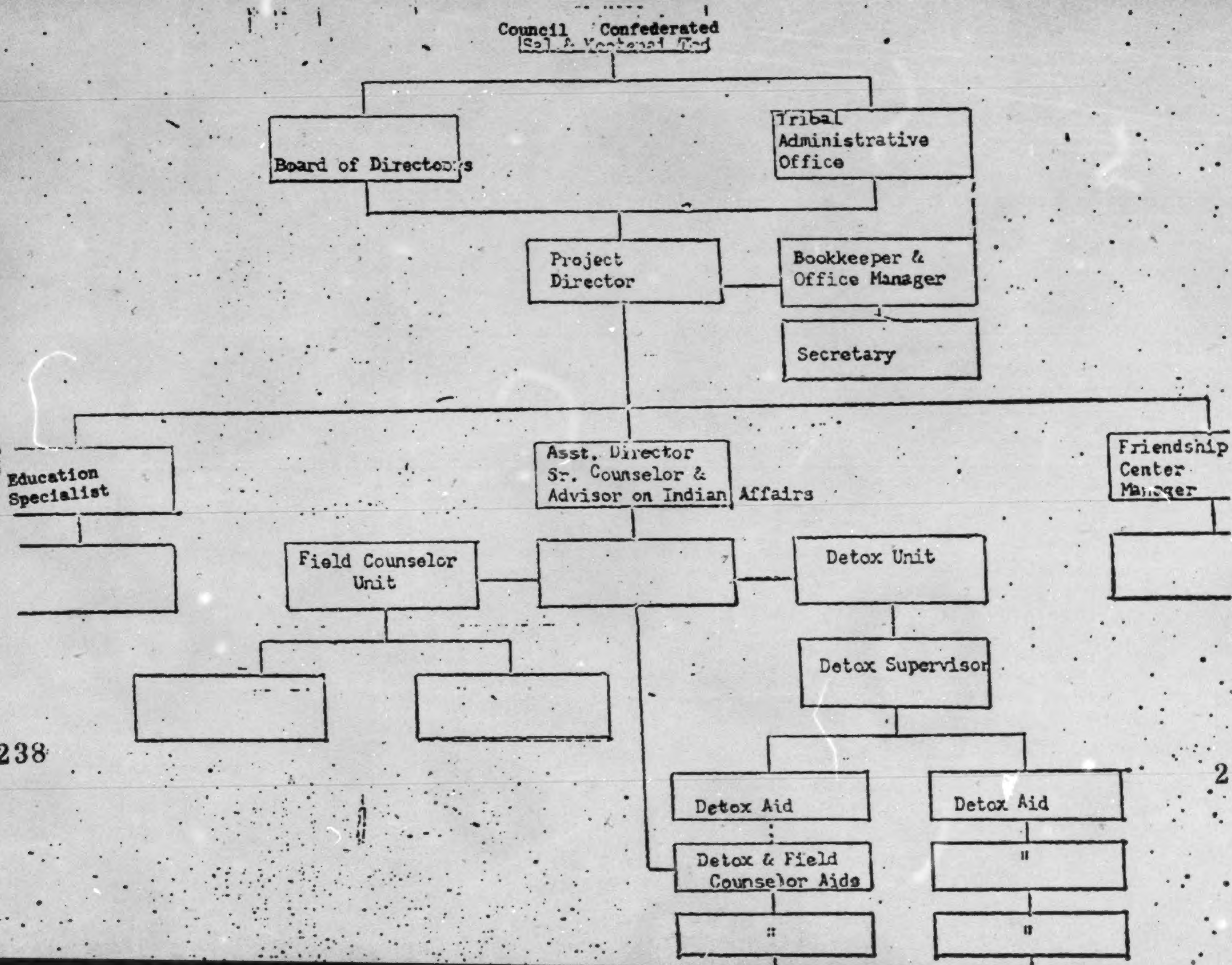
Attachments

cc: Chief, Contract Health Services, IHS
Rockville, MD

CHS-BAO

Unit	Admissions	Funding Sources (Other than NIAAA F.Y. 1975)	Present Staff	Additional Funding Needed to Meet Minimum Staffing & Program Needs
Blackfeet	331	IHS - $34,860 Detox State of Montana - $19,000 HWH	1 Supervisor 2 Counselors	$14,000
Crow	303	IHS - $35,840 Detox State of Montana - $20,000 HWH	1 Supervisor 4 Counselors	
Fort Belknap	66	IHS - $32,000 Detox State of Montana - $27,000 HWH LEAA - New Building	1 Supervisor 2 Counselors	$14,000
Flathead	170	IHS - $44,560 Detox State of Montana - $13,400 HWH Tribal Revenue Sharing for construction of comprehensive facility - $110,000	1 Supervisor 5 Counselors	-
Fort Washakie	88	IHS - $10,000 Detox State of Wyoming - $33,500 HWH & Detox	1 Supervisor 2 Counselors	$14,000
Fort Peck	174	IHS - $70,000 Detox-HWH State of Montana - $17,500 Youth Program Tribal Revenue Sharing - $5,000 Thrift Shop	1 Supervisor 5 Counselors	-
Northern Chey[illegible]e	185	IHS - $32,500 Detox	3 Counselors	$14,000
Rocky Boy's	90	IHS - $30,000 Detox State of Montana - $6,000 HWH	2 Counselors	$21,000
				$77,000

HWH - Halfway House


Council Confederated
Sal & Kootenai Trd
Board of Directors
Tribal Administrative Office
Project Director
Bookkeeper & Office Manager
Secretary
Education Specialist
Asst. Director Sr. Counselor & Advisor on Indian Affairs
Friendship Center Manager
Field Counselor Unit
Detox Unit
Detox Supervisor
Detox Aid
Detox Aid
Detox & Field Counselor Aids
"
"
"

F.Y. 1976 MONTHLY DATA REPORT
Detox Program

Total number of clients admitted this month to Detox: Male______ Female ______

Number of new clients admitted to Detox this month: ______________.

Total number of
1. Self referrals ______
2. Law & Order ______
3. PHS ______
4. Industry ______

Total Repeat Admissions to Detox:

Female:

2-4 Detox admissions____ 5-10 Detox admissions_____ 10 or more Detox admissions_____

Male:

2-4 Detox admissions____ 5-10 Detox admissions_____ 10 or more Detox admissions_____

Total Number Detox Clients this Month by Age and Sex:

Female:	14-19______	20-24 ______	25-29 ______	30-39 ______
	40-49______	50-59______	60 and older ______	
Male:	14-19______	20-24 ______	25-29 ______	30-39 ______
	40-49______	50-59 ______	60 and older ______	

Treatment Modalities Being Offered Following Detox:	Number of Clients Involved
1. Group Therapy	________
2. Individual Counseling	________
3. A.A. Group	________
4. Recreational Therapy	________
5. Home visits	________
6. Family Therapy	________
7. Marital Counseling	________
8. Youth Group or peer counseling	________
9. Involvement of medicine man	________

Number of clients employed following treatment: Male______ Female_______

Referral to Other Resources:

1. Vocational Rehabilitation ______
2. BIA Social Services ______
3. Galen ______
4. Sheridan ITATC ______
5. V.A. Hospital ______
6. IHS-Mental Health ______
7. IHS-physician ______
8. Law and Order ______
9. Community Mental Health Center ______

Prevention/Community Education:

Number of speeches given ______

Number of educational or rap sessions held with high school students ______

Number of educational sessions held with grade school children ______

Number of radio, T.V. appearances or newspaper articles ______

Staff Inservice Training:

Local level Subject

Outside local area (identify location) Provided by whom

VII. SUMMARY AND CONCLUDING COMMENTS

A. Achievements of Mental Health Programs in the Billings Area

The following accomplishments over the life of the program can be identified:

1. The program has grown in ten years from one part-time contract for psychiatric consultation to add full-time professional staff on seven of the Service Units and on eight of the nine Reservations in the Billings Area.

2. This growth has been accomplished while still maintaining relationships with local professional staff who continue to offer contract services. This establishes a viable frame for a network of interrelated services on and off the Reservations. It increases the possibility of local non-Indian concern and understanding for the problems of the Indian people who are their neighbors.

3. Several programs demonstrate the use of contracts with tribal groups as a means of developing innovative programs. Indian initiative and responsibility for a realistic partnership seems to emerge from the negotiations around such contracts. Deployment of professional expertise is often achieved more appropriately than in many paternalistic federal settings.

4. In-service training and an A.A. degree program have been developed cooperatively, utilizing local resources. The shared experience of participation in this training program may be a unifying force for Area staff. It should also result in improved service delivery.

B. Problems to Be Resolved in Mental Health Programs in the Billings Area

1. Although successful in negotiating with external agencies as resources (V.A., CMHC's, private medical facilities, etc.) and as receivers of services (Tribal Alcoholism programs, for example), the Mental Health programs and staff seem to have real difficulty developing rapport and support within IHS.

This is due in part to changes in IHS medical and administrative staff in the Billings Area and partly due to personality clashes involving Mental Health Program staff, which reverberated through the system.

2. There has been a lack of a sense of prior program history and roots, both at the Area and Service Unit level. This periodically gives some personnel the false impression that Mental Health Services have started with them. While sometimes a cleaned slate is desirable, more often the impact of prior programs and services affect both associates and clients. Explicit knowledge of the past could make some reactins to programs less mystifying.

3. Decentralized deployment of staff has been so successful that communication within the Area has at times seemed minimal if not missing altogether. This increases the sense of isolation of professional and paraprofessional staff, sometimes to an intolerable level. This not only affects morale, but also tends to make it difficult to see any unified planning or themes at the Service Unit level. It is not easy to find a balance between optimal autonomy and desirable shared goals, methods and programs.

4. There were relatively few programs aimed at children or youth and almost no evidence of planning for preventive interventions.

5. No research or epidemiological studies seem to have been made a part of Mental Health program planning.